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PRODUCTIVITY COMMISSION REPORT ON MENTAL HEALTH SERVICES IN AUSTRALIA
Response from Mental Health for the Young and their Families (Victorian group) (MHYF Vic)

Introduction

MHYF Vic regards the draft report from the Productivity Commission on Australia's mental health services favourably and endorses many of the initiatives outlined. We provide a detailed response to each of the draft recommendations, findings, and information requests in an attached document. However, we regard these recommendations and findings as likely to provide the basis for renovation of the system. We strongly endorse the recommendation to rebuild the system, but do not feel the principles for rebuilding have been clearly articulated. Each of the five reform areas have been appropriately identified, but are sites for action, not principles for action.

More, the principles for action have to be operable at the case level by clinicians, consumers, and carers.   We support the provision of resources for new facilities and improved governance, but are skeptical about an approach which is top-down.   We would like to suggest that the principles for rebuilding the mental health system in Australia from the bottom-up to enhance productivity and service to consumers are:

1. Early childhood prevention programs (maternal and child health, and pre-school)
2. Trauma-informed responses and training for all practitioners
3. Family-based and development-based intervention training for all practitioners
4. Redesigned access systems
5. Active facilitation of collegiality (including consumers and carers)

There is much MHYF Vic could comment upon in the draft report and we fear we do not have the time to give the details the focus they deserve. So much of the draft *Productivity Commission* report bears on MHYF Vic's experience. We endorse the one oversight body as an important factor and endorse the Rebuild option. However, we think the report lacks a practitioner's view of how to implement sustainable change in the system. We are talking about the view of the ordinary, everyday practitioner in the consulting room.

If MHYF Vic were to redesign the mental health system, we would like emphasis on the following formal or structural characteristics as priorities of any re-design:

- Prevention programs
- Integrated and coordinated, user-friendly access to MH services
- Collegiate, collaborative procedures (including funding of case conferences)
- Developmental understanding of the emergence of mental health conditions
- Early intervention
- Family-informed models of intervention; especially, engaging with consumers and carers
- Family trained practitioners reluctant to reduce problems to individual level
- Trauma-informed models of practice
- Family-based models for intervention with ADHD patients
- Long-term stay options for severely disturbed patients

- Long-term therapy options for severely disturbed patients
- Re-design of crisis intervention and crisis-stay facilities
- Aboriginal control of Aboriginal health services and cultural training for staff
- Focus upon children in out-of-home-care
- Focus upon family-based responses to post-natal depression
- Active engagement with Human Rights' principles in the treatment of children and adults
- Active solution finding to problems of agency interaction, especially public and private exchange, but also child and adult services

The five principles given above cover this list of priorities. The principles are not intended to be chronological or prioritized, although it is efficient to discuss these chronologically. The overall aim is to maximize the efficiency and productivity of the system from the bottom-up. Structural solutions need to make sense to the ordinary, everyday practitioner and to the consumers and carers.

MHYF Vic thinks that four emphases of the draft report are misplaced. These concern evidence, individual service, school-based mental health services, and suicide prevention. Two matters require more emphasis: the views of consumers and carers and the operability of the system by the ordinary, everyday practitioner. Before the five principles are discussed our reservations about these emphases need to be presented.

Evidence

MHYF Vic strongly supports evidence-based service initiatives, but the evidence-base is weak in the key areas and evidence derived in specialist settings is being inappropriately used to prescribe intervention in community clinics. Most mental health presentations involve multiple diagnoses and much complexity.

In the area of clinical psychology, in particular, models of practice based on a university-clinic controlled trials with mild cases of attending clientele and singular diagnoses, have come to define "gold standard" practice. Such cases are distinctly different to usual presentation in public practice and even in much private practice. All cases have complexity due to psychosocial circumstances; the effects of such factors on the capacity to deliver standard procedures can much outweigh handbook prescriptions for practice. To get people help in such circumstances requires deviations from all manuals. The key issue is in building a working relationship, a factor little addressed in psychotherapy manuals beyond the cursory need for politeness, patience, and calmness.

That is, in the area of psychotherapy practice, evidence-based approaches have stifled the development of models of practice for real world situations. Coming back down the evidence pyramid, there is plenty of case-based evidence and quite a bit of commonsense that can direct sensible, sustainable, and effective therapy for people with complex presentations and adverse circumstances. MHYF Vic suggests that a side product of any recommendations form the Productivity Commission could be a recommendation for research of therapy under usual conditions.

In putting forth the argument for the implementation of a family/developmental approach to mental health problems, MHYF Vic is supported by the over one hundred years of practice within child guidance (now child and adolescent mental health, CAMHS) of team-based work that looks at the whole family and its development from social, medical, and psychological perspectives. This model has never been applied consistently in adult mental health settings and this needs to occur. The evidence is strong.

Whenever MHYF Vic refers to evidence in this response to the draft report, we mean evidence as it is normally thought about, not evidence concocted within laboratory-modelled mental health clinics with tight manuals and with attending people with singular diagnoses. Also, we are not criticizing the need for tightly controlled experiments with new pharmaceuticals, but would like drug innovators to consider wider psychosocial effects of their drugs. One of these effects is to individualize treatment.

Individual service

As might be inferred from the above, MHYF Vic locates many of the problems with adult mental health services with the focus upon the individual, especially with monitoring of the individual. Humans are social animals, yet, in mental hospitals they are treated as if separate from those they have known all their life. More, through the processes of confidentiality and consent, barriers are built in to prevent communication with loved ones.

MHYF Vic is arguing for a mental health system that seeks solutions to mental health problems that might lie between people, rather than just within the body of a separated person. Treating an individual is more likely to focus upon adjusting the internal state and monitoring deviations in state. Focusing on family- or community-based solutions has monitoring as an ordinary effect of interaction and draws forth resources for the person not located within an individual treatment model. There are untapped psychosocial resources for the mentally ill that might be drawn upon if the treating professionals tried to engage with the wider networks in which a person lives.

This is not to say that collaborative, coordinated, transparent, and integrated service is easily provided. It is difficult to establish; it requires investment in training of professionals and a change in perspective across the whole mental health system. But it is more likely to be both efficient and productive than the current individualizing system that many consider broken.

Further, although not as commonly practiced in CAMHS public services as it once was, collaborative, coordinated, transparent, and integrated service has a long history of effectiveness.

School-based mental health services

The Victorian Government has already proposed to place more mental health practitioners in schools. MHYF Vic does not think this will be efficient because the counsellor's office door is a threshold of stigma. Secondly, the counsellor is in a position of structural conflict of interest within the school and within the family of the student. We are sure that some school counsellors manage the problems of conflict of interest well, but this probably has much to do with the service consumer as the counsellor. Structural conflicts of interest make for inefficiency. Being on campus addresses apparent problems of access, but creates other access problems that have always been the more important problems of access: stigma and confidentiality.

MHYF Vic does think educational staff need the support of mental health practitioners to help with students with particular special needs (temporary or ongoing), with classroom management, and collegiate case management involving other practitioners (public and private). We believe that experienced practitioners within schools need to develop suitable position descriptions with particular skill bases. We think these new practitioners need to be well trained and introduced within an overall "change management" strategy for the whole school. "Change management" within schools has been an ongoing project of the Victorian Government and needs careful implementation.

As early intervention available on a population-wide basis, intervention at schools has appeal. But the same level of accessibility could occur at maternal and child-health and pre-school centres and with greater effect and efficiency because the interventions would occur earlier and would involve familial cooperation. Another problem of school-based intervention is that it has to occur outside of the involvement of parents, and this can make for chronic miscommunication between child and parents and school and parents. Earlier intervention would happen in conjunction with the family and address such important destabilizing factors as post-natal depression, substance use, and sibling rivalry.

Suicide prevention

Suicide prevention and renewed response protocols, like counsellors in schools, seems a relatively easy solution to the big question of productivity. There are two problems when trying to prevent suicide: finding those who are suicidal and having sufficiently accessible, calm professionals able to respond actively. We think the current system puts professionals in harm's way. This does not mean we do not need to refine crisis response to these dangerous situations; rather we need to build in better support systems behind the practitioners.

Secondly, the numbers in the severely disturbed group of mental health patients who are suicidal are similar in raw numbers to those in the moderate and mild mental health groups. Any aim to reduce overall rates of suicide needs to address those hidden among the moderately and mildly affected groups, as those who are in the severe group are probably being watched quite well in the course of professional consultation. That is, refinements may improve some case outcomes and lower overall rates by some degree, but dramatic change requires structural intervention through preventive innovations yet to be devised.

Again, wise practitioners in this field need to be consulted to find a better design, and change needs to be managed within the overall system, to allow for calm, firm responding by professionals. Early intervention with families attending pre-school and maternal and child health centres is likely to preclude suicidality, especially when the problems are connected with post-natal depression, parental substance use, and sibling rivalry.

In other words, system redesign can decrease rates of suicide and improve the mental health of youth, but direct funding of specific initiatives is unlikely to produce change.

The consumer's and carers' view

MHYF Vic is an organization that includes carers and consumers and advocacy groups for carers and consumers. We take this part of the mental health system very seriously in a way other professional groups and mental health agencies seem not to do. We believe in collaborative, coordinated, transparent, and integrated service, as stated previously. This means inclusion of consumers and carers in case conferences and case decision-making in most circumstances. We accept that sometimes consumers are too ill to make decisions and sometimes carers have purposes that are not in the best interests of the consumer. But we do not believe practitioners always act in the best interests of the consumer and without carer and consumer voice such abuses of power make for even more vulnerable or disabled consumers.

Consumer and carer advocates are needed at all levels of the system, especially at the case level, but also within agencies at the policy level and within higher levels of government. Consideration of consumer's best interests need to be an ordinary part of case management and of government policy and professional training. Training is needed for consumers and carers by consumers and carers.

The ordinary, everyday practitioner

Notwithstanding any of the above, MHYF Vic believes that the service system needs to be able to be enacted by ordinary, everyday practitioners using protocols designed for collaborative, coordinated, transparent, and integrated service. We believe the adoption of the five-component model of case management described below (Initiative 4, Part 4.2) can deliver such service. The model is transparent and self-adjusting because all case team members, including consumers and carers, can check the adequacy of a treatment plan against the model.

The ordinary, everyday practitioner will require training in: the five-component model, facilitating access, working in case teams with consumers and carers, family-based interventions (including relevant cultural training), trauma-informed interventions, and developmental understanding of mental health problems and their trajectories. It would be best if such training occurred among collaborating agencies within regional districts with workers of various training and agency origin learning in a collaborative team-based seminar format. The training should include generation of options for specific case presentations encountered in the local area, given the local service availability and geographic distribution.

Initiative 1: Early childhood prevention programs (maternal and child health and pre-school)

Prevention needs to be provided without stigmatization. Families do have children who attend maternal and child health centres and pre-schools. Child behaviour is a usual subject of discussion between carers and the respective practitioners. Problems of mental health, substance use, and sibling rivalry are picked up within such settings. Referrals can be made while attendance at the facility is maintained. Nobel laureate economist, James Heckman, demonstrated the economic benefits of pre-school education as pre-school education addresses the whole child in the context of their family, and mental health issues are readily identified and intervention can be mobilized.

These facilities and these practitioners provide a less threatening venue and less intrusive view of the early markers of family disruption. Preventing trauma and family breakdown potentially avoids intergenerational transmission of trauma and mental health difficulties. Detection of post-natal depression can avoid similar transgenerational effects. Resolution or diminution of sibling rivalry is protective of family dysfunction in the adolescent years.

Initiative 2: Trauma-informed responses and training for all practitioners

There are two primary sources on mental health problem transmission that have been hypothesized. One is genetic susceptibility and the other is family dysfunction. The problem is that both can produce similar outcomes in the next generation. Further, the manifestation of the difficulties is likely to impact other family members as trauma-induced anxiety, depression, or other symptoms including self-harm, even if the genetic predisposition is the source of the original destabilization of the person.

Professionals are being trained better to respond to trauma-based mental health problems, but improvements in service are still lagging. Being calm, firm, and responsive is a challenge that requires specific training and sound personal emotional regulation. The system needs to invest in this form of interventional skill set.

Understanding trauma and its effects is especially important with Aboriginal families, substance users, self-harming and personality disordered consumers, and children in out-of-home-care: understanding how to begin to respond is crucial.

Initiative 3: Family-based intervention training for all practitioners

Family-based intervention is more difficult than intervention with individuals, because there is more complexity in the transactions, but it can be much more efficient as family resources become available to the problem of responding that might otherwise be ignored or be inaccessible. Family therapy has long demonstrated its capacity to find workable problem solutions in less time. But there needs to be a change in practitioner mind set and service procedures to more adequately accommodate family-based responding.

Training of practitioners in a sequenced level of skill and understanding needs to be designed and provided on a focused way but broadly available. Most post-graduate courses do not provide adequate training in family-based responding and intervening.

Procedures for family-based inclusiveness at point of access our described in the next section.

Initiative 4: Redesigned access systems

Part 4.1: Access as clinical specialty

Successful mental health access is about a perceived willingness to function with compassion, efficiency, professionalism, authority, and without stigmatization. The establishment of these criteria in the mind of the potential consumer is critical to the work of the first contact agent (GP, emergency room nurse, MH agency referral and intake worker). If efficiency is placed ahead of compassion, contact begins poorly. If professional stance is placed ahead of efficiency, the consumer will doubt that they are being heard. If expertise is placed ahead of listening, the beginning may never lead to intake. However, if the contact is not professional and authoritative, the consumer is likely to feel vulnerable. Stigmatization will exclude. First contact work is a clinical discipline and a clinical art. The role needs to be elevated and legitimized. This new role is that of the Networker.

Currently access to services is uncoordinated, haphazard, and subject to uncertainty of outcome. Consumers report insecurity about approaching, heightened sense of stigma, and a fear of being judged or not being heard. Potential consumers need a means of access that leads to positive outcomes in a way that can be expected. Carers of consumers need the same things. There are two parts to the new access model; one is description of the processes of greeting and intake, and the other concerns the family engagement process, which will be discussed after the general processes of access.

However, the actual practices of professionals at the initial interface will vary according to the point of access (GP practice, emergency room, MH service) chosen. The methodologies of access need to be set down quite clearly, but first the purpose of access reform needs to be described. Then the principles for action need to be articulated. Then the actual practices can be formulated.

Access to services needs to be timely and to encourage efficient contact with the most appropriate professional. The transaction needs to be respectful, especially of reluctance and fears about stigma and judgements. Once the first contact has been made and the consumer connects with the best appropriate professional, some of these processes will necessarily be repeated, but should not occur in a tiresome way, as the consumer will be wanting to get on with finding out if the professional is the best available person and what might happen as contact proceeds. It is not enough for the professional to have confidence

to help a consumer. The consumer needs to have solid evidence that the consumer will be taken seriously, respected, not judged, and, actually, helped.

The Networker needs to be someone involved with referral and intake duties who would have extra duties, or someone who works solely in the defined role. The role has the following functions:

- Actively seeking to link consumers with important family and friends who may have become remote to the consumer, but who would like to contribute to the consumer's wellbeing,
- Trace lost connections,
- Facilitate initial meetings, and
- Follow-up where necessary, but leave subsequent interactions to the professionals already involved.

The role is specialist and is time-limited. The Networker is not a case manager, but aids and supports case management. Other changes can support case management efficiencies, as well.

In recent years, the trend has been to consider the first contact role as akin to emergency room triage, but this is a mistake. PhD research by (Grimwade, 2006) distinguished the triage function from mental health access consultancy in the following ways: for mental health access there is neither a no treatment nor death option; action has to occur, if only to suggest alternative options. Secondly, triage involves minimal conversation and much expert action; mental health access requires respectful conversation and consented action. Thirdly, mental health access involves developing trust and security with an unknown system; triage involves rapid decision-making about subsequent actions that have relatively clear and pre-determined outcomes. Triage involves minimal time; mental health access takes as long as it takes, often this can mean a half-hour telephone exchange.

The primary purpose of access consultant is to encourage contact with the best available professional. How a GP or emergency room professional enacts such a transaction needs to be informed of this primary purpose and not to act in triage mode. Similarly, the mental health agency intake worker needs to have a similar attitude; but it is probable they already intuitively act this way, or, at least, that is what was reported in the research.

The principles for action are relatively straightforward: take time to facilitate a positive attitude to a process that may hold fears, help the consumer consider alternatives, offer alternatives, prepare the next professional for the possible presentation of the consumer, and provide details to ensure the consumer knows who to contact, how to contact, and where to go. Answer questions that help frame the consumer's expectations in a realistic way that has a view to the several steps that might be involved.

One aspect to the principles for action concern the permeability of the tertiary mental health services: the walls are too high for access to these services. Too many people needing highly skilled response are excluded. This is especially true in cases of suicide where inpatient care is warranted in the less severe mental health presentations as suicide attempts are more characteristic of less severe mental health problems.

We are also concerned by the operational rule of CAMHS that children in out-of-home-care rarely are accepted. The premise is that specialist help for recovery has to happen against a background of stability of the placement. We believe that treatment creates the conditions

for stability otherwise not able to be obtained by child, parents, or carers. We believe carefully thought through integrated interventions help severely disturbed children in care.

The actual practices will vary according to contact context. The protocol for referral acceptance and intake action can be defined quite closely for a MH agency and could be used by other first contact agents to establish their own protocols. It should be obvious that this is not a triage protocol.

Stage 1: Greeting the potential consumer and establishing if the agency is appropriate to discuss consumer needs

Stage 2: Initial data gathering; confirming appropriateness or starting to consider alternatives

Stage 3: Considering alternatives; making suggestions and establishing timelines for action. Establishing connectedness with others of the consumer and who would enable referral and subsequent contact (family, friends, employer …)

Stage 4: Explaining mechanics of referral and intake and answering questions about reluctance, stigma, and judgements. Discussing participation of others

Stage 5: Planning for alternate pathway or taking referral data

Stage 6: Smoothing the way for internal or external referral and intake; seeking consent to talk to others, including important supports; termination of contact making expectations of next steps clear, once more

Stage 7: Documentation and checking of data; passing on information in timely way

The purpose of initial contact with the best available professional is to establish in the mind of the consumer that the professional can be helpful, will listen, and will not judge.

The principles for action, again, should be straightforward: address concerns, describe approach, describe collaboration with others, describe short-term and immediate goals, describe how assessment leads to treatment and the period over which contact might occur, and then gain signed consent for engagement and for contact with important others (professionals, family, friends, employers …).

The actual practices will vary, again, according to contact context, but also with respect to presentation, engagement with important others, participation of other professionals, and to treatment options that the professional might use. The processes whereby important others are engaged need also to be described. Although, actual practices for particular agencies cannot be prescribed here, the details should be able to be used to generate specific protocols for action.

Family engagement should be integrated into the processes of access. The procedure described here is focussed on engaging with family members estranged by time, events, or geography. The process would not be so complicated if the consumer is willing to meet at the agency with parents, or sibling, or other, who has remained in contact with the consumer. The people most compromised by mental illness are often the ones most estranged or isolated, and the ones with important others more reluctant to be involved. A secure and conservative process needs to be implemented for such cases. But then purpose of connection as part of the solution should remain a clear purpose.

Where possible, at the first point of contact for the consumer, attempt should be made to gain a listing of family members (and other important persons) by name, birthdate, probable

address, and telephone number. This may not be possible within the scope of a request for a referral, but needs to be collected early in the process to emphasize the importance of gathering resources from concerned others as a means to providing support and generating solutions that are family based.

Consent to contact important others needs to be obtained; this is better in signed form, but agreement over the telephone should be sufficient to begin the process of finding others who might be willing to contribute to recovery.

The consumer and professional can then use a letter template to personalize a message to potential supporters of the consumer. This is then sent by the agency to the potential other seeking engagement in the process of recovery. Included with this mailing would be another template letter that an important other could use or modify to send back to the agency consent to be contacted or not, with contact details provided where necessary. Once received the agency would contact the important other and discuss the next processes.

When ready, the consumer and the potential supporters would meet at the agency with the focus upon what all could contribute to wellbeing and harmony. This would enable the completion of the five-component set of interventions in cases of severe mental illness and in cases of sub-clinical presentation.

The role of the professional overseeing this process of connection in MH agencies needs to be defined. In private practice services, the functions of the role would need to be understood and acted upon by the professional concerned. For lack of another title, it is proposed to call this professional the Networking Agent or Networker.

Part 4.2: A five-component model for coordinated and integrated intervention

One of the major criticisms of the existing mental health system concerns the lack of coordination and integration of services and interventions, the lack of a multi-disciplinary team approach, and a lack of conceptual coherence. It is proposed that the model presented below will be understood immediately by many in the child and adolescent mental health field and by many who practice with adults, as this equates to ordinary practice.

The significance of the model is that it has finally been articulated in a way that can help unify and integrate intervention through multi-disciplinary work. The model provides a simple test of adequacy of response (have we covered all components? and, do the interventions fit together?) that can be communicated between professionals and agencies and provide a readiness of accountability. It is hoped that consumers and carers could use the model to check if adequate and integrated services are being provided.
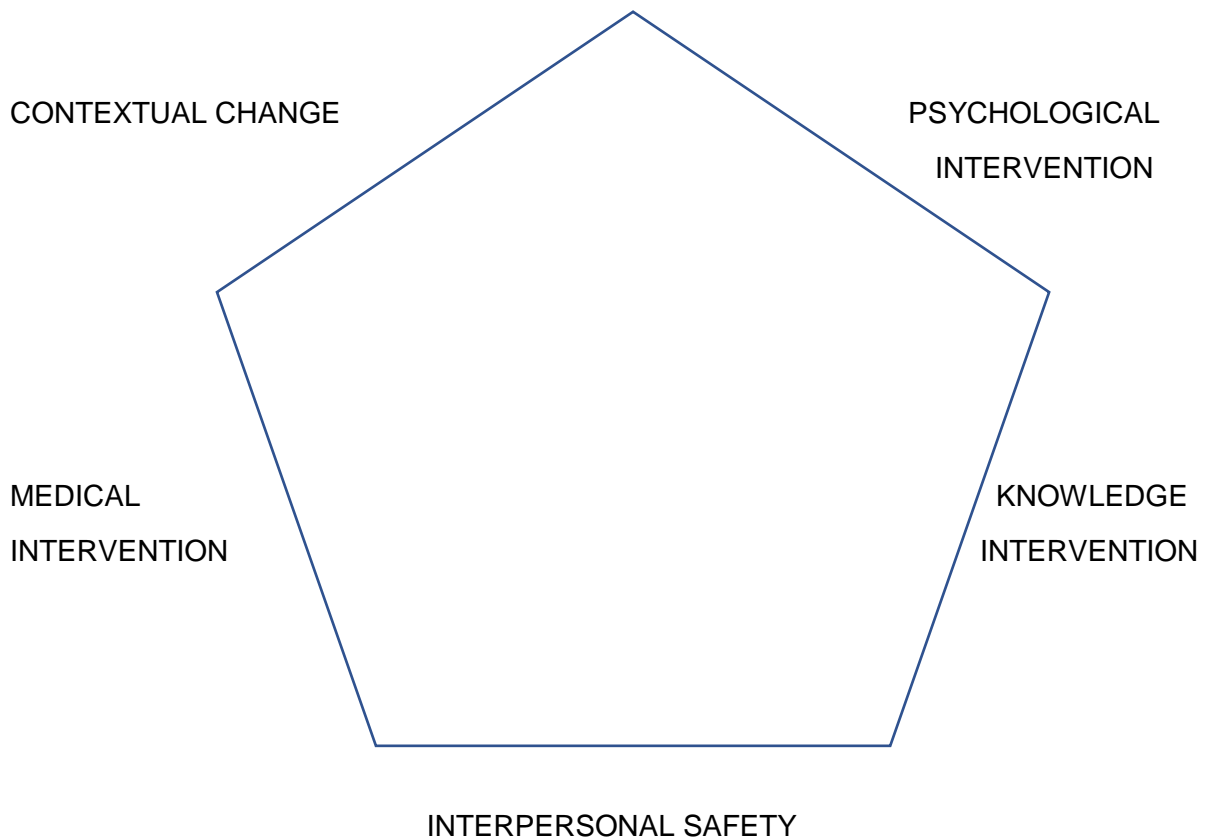
This model arose through practice with adults with Attention Deficit Hyperactivity Disorder (ADHD) and presented at the recent 7th World Congress of ADHD (Grimwade, 2019). The more general applicability of the model was recognized during the presentation. It is presented diagrammatically, below. In fact, the model has been in practice for many years, but has not been formalized.

The five components are: Interpersonal safety, Medical intervention, Knowledge intervention (psycho-education), Psychological intervention (trauma focus), and Contextual change. It is proposed that effective intervention has always required action on all these fronts, but the links between each intervention have usually been generated on an ad hoc basis, and the overall structure of interventions had been hidden, even though the participating multi-disciplinary professionals (psychiatry, psychology, social work, occupational therapy) provide

interventions that cover each of these components. This is not a new model; it is an articulation of current practice that formulates integrated practice.

It has been pointed out that the five components could be arranged diagrammatically as points on a star, which has some appeal. However, the pentagon is preferred as a pentagon contains within its boundary all the professional and consumer activity with respect to mental health difficulties, and describes the necessary lines of communication. Secondly, a pentagon has a firm base which corresponds well with the notion of interpersonal safety. Thirdly, a pentagon comes to a peak that indicates a shared direction of purpose. A star could imply heading off in five different directions. This is a metaphor for the work, of course, but the image of containing and collaborating is helpful to understanding the shared task of all involved.

All five components are needed, but there is a natural sequence of interventions. Interpersonal safety concerns precede all intervention; a consumer needs to feel safe before being able to commit to a program of intervention. Early on, medical examination is needed to rule out physical causes and to assess the constraints that any physical conditions may have upon a program of recovery. Almost at the same time, and to enhance feelings of safety and professional trust, the consumer needs sensitive and accurate education about presentation, about potential treatments, and about timelines for action. All of which requires appropriate communication that addresses any concerns of consumers and of important others. Important others need to be included to enhance safety and to support intervention.

CONTEXTUAL CHANGE   PSYCHOLOGICAL
                                                          INTERVENTION

MEDICAL   KNOWLEDGE
INTERVENTION   INTERVENTION

INTERPERSONAL SAFETY

Psycho-education (knowledge intervention) need not be provided by the medical team member; social workers, psychologists, and occupational therapists can be involved, especially if they are to help with the other forms of intervention. At some stage, psychological work will need to be done, if only to address the trauma of the period of

distress; but often long-term work on sources of trauma will be required. Similarly, the network of persons associated with the unwell consumer need to be consulted and sources of exacerbation of symptoms and sources of support investigated. In cases of adult ADHD, for instance, after medication and psycho-education and the beginnings of trauma therapy, partners, family, workplaces and work colleagues, and friendship groups need to be considered, perhaps just through the consumer, in order to find ways to enhance the social situation and to remove sources of negative influence (for example, drug dealers, bullies, marital conflict). Family therapy or couple therapy might be useful. It is suggested that this last option, often overlooked, can further enhance safety and speed up the effects of other interventions.

Interpersonal safety is difficult to define and is often overlooked. Existing practice holds that the consumer should give esteem to a diagnosing psychiatrist by virtue of training and position. It should be assumed that a professional will act with integrity and respect. This assumption obscures the simple observation that unwell people fear external control and do not easily welcome the intervention of powerful figures. The perception of undue force is not far from many people's consciousness when they encounter the mental health system in an unwell state, particularly if they have had unhappy outcomes in the past.

All professionals need to attend to the interpersonal safety needs of the consumers within their care throughout all periods of contact, and especially in the initial stages. In turn, such attention increases the safety of all present and subsequent practitioners who do not have to encounter fearful or dangerous consumers distressed by their presentation and the initial greeting. Included here would be sensitivity to physical needs, cultural practices, and other differences of ethnicity, religion, sexuality, or disorder (for instance, personality disordered people at presentation experience high levels of antagonism directed against them, independent of the actual behaviours of the professionals). Interpersonal safety is best determined contextually by being engaged with levels of arousal and distress within the consumer.

Part 4.3: Intervention services for substance users with mental health needs

Substances that affect consciousness have an ancient history, but in contemporary times, mind-altering drugs have been able to be manufactured in relatively modest laboratories and sold through networks outside any legal framework and beyond Police detection. Poly-drug use is commonplace. Many of the drugs cause biochemical addiction that resists attempts by users to be rid of damaging drug habits.

Illicit drugs have many damaging effects beyond addiction. Changed behaviour affects family harmony and increases the risk of domestic violence. Drug habits affect family income, productivity at work, and employability. Drug habits lead to connections with networks of crime and to periods of jail. Illicit drugs, when poorly manufactured, can be lethal. Many users disregard such risks.

Substance use is significantly implicated in cases of removal of children from unsafe homes due to neglect or abuse. In turn, the addicted parents find the pain of loss of the children to be only assuaged by the drug abuse that caused the removal in the first place. Similarly, lost adult intimate relationships fuel the urge to use.

The interaction between mental health and drug use is complex. Drug use may precipitate mental ill health. Mentally unhealthy people may seek relief in illicit drugs. The cycle of use

and distress is reinforcing. Personality disorders can occupy a space between drug use and psychological distress. Both are individualizing experiences.

The best antidote is to bring the person back into connection with others; who may be family, friends, health professionals, or other users. The process is likely to take a long time and is likely to include periods of relapse. Group programs are important as the longevity of Alcoholics' Anonymous has demonstrated.

Part 4.4: User's guide to collaborative, transparent, coordinated, and integrated mental health intervention for case planning, for ongoing process, and for accountability

The five components for integrated intervention in mental health practice are not abstract ideas. They have been used for over a century. The innovation, here, is that the accumulated wisdom of the field has been articulated through packages for treatment.

In each case plan, each of the components needs to be considered, along with assigned roles for particular practitioners and communication lines established. With all participants having expectations of case planning using the five-component model, efficiencies in the process will be developed and connections made that will expedite future case planning.

4.4.1: Case planning

The first contact agent (intake worker, GP, ED nurse, family member, youth worker, Maternal and Child Health Nurse, pre-school educator, employer, solicitor, Housing officer, Police officer …) needs to locate the professional most suited to the role of Interim Case Manager. This may be a lasting role, but is crucial to beginning with a comprehensive approach.

The Interim Case Manager needs to help the consumer (and connections) feel comfortable with seeking treatment and with the process of developing a case plan. If a GP is the Interim Case Manager, arrangements would be made for consumer (and connections) to be assessed medically and psychiatrically, while information is provided about treatments, other referrals, and prognosis: such knowledge will enhance the sense of interpersonal safety.

Referral for psychological assessment needs to occur with relative haste and, through liaison between those already involved, decisions would need to be made regarding management of psychosocial and contextual needs. It may be that many of such factors can be managed by the consumer or family members. The psychiatrist and psychologist may be able to help with these matters. Within a public mental health service, a Social Worker may provide such services. The key is to check if all five components are covered and processes put in place to address particular aspects of each component, as the need arises.

Each case plan should involve options for future action as the consumer moves back into the community and confronts possible relapse or other adverse circumstances.

4.4.2: Case process monitoring

Once the treatment plan is established, agreement on roles, responsibilities, ongoing case coordination and communication patterns need to be affirmed. In some cases, this may only require exchanges between the GP and the psychologist, with infrequent psychiatric review. Within public mental health services, case management teams (of psychiatrist, mental health nurse, social worker, occupational therapist, and psychologist) might require weekly meetings. In all cases, frequent communication with the consumer (and connections, if warranted) would be needed to ensure interpersonal safety and not to overload the consumer with professional input.

4.4.3: Accountability

The five components for integrated intervention can be used to ensure accountability. The consumer and carers can point to each component and ask the professionals to explain how and when certain needs will be addressed. Third parties, such as friends and neighbours, could also point to other needs or express concern over the case plan. Other professionals, like solicitors or physiotherapists, may be able to ensure that their clients, who have mental health care plans, are being appropriately and comprehensively treated in an integrated and coordinate way.

4.4.4: Transparency

The five-component model allows for carers and consumers to check on the interventions being offered in terms of adequacy, coordination, and breadth. That is, the interventional package is transparent to those for whom the package is provided and open, therefore, to refinement from the consumers and carers. Mental health intervention has not had transparency as priority in the past; with this model, transparency is a given that professionals will need to recognize in their transactions with their patients.

4.4.5: Integrated intervention

People live in connection and resources can be drawn from communities and families to support a person with mental health needs. Integration requires a case plan that covers the five components and is coordinated, with clear lines of communication.

It is asserted that integrated and coordinated intervention plans will make intervention more efficient in each case, although this may be time-consuming, initially. The delays in putting a plan together will recede as the understanding of the plan and its elements grows

It is expected that connections will develop between professionals across public and private lines and within particular clinics. Enhanced cohesion across the system will be built on a case by case basis. Integration of services will be built from the bottom up, and with consumer involvement.

Part 4.5: Zero waiting list intake and short-term treatment as a potential model for referral response

It is possible to run a zero Waiting List intake and short-term treatment program, but it requires rigorous timetable management. The time required for treatment is the same as when there is a waiting list; the difference is when the treatment is provided.

All accepted referrals are offered an intake appointment within one week of contact. This requires the Networker to reserve appointment spaces for the anticipated interviews. Crisis same day referrals require special flexibility, which can be dealt with by reorganising the administrative hours. All new cases are scheduled to have ten hours of casework time and ten hours of administrative time, normally spread out over a ten-week period. Every face-to-face client contact hour inevitably consumes a further administrative hour of report writing, telephone calls and liaison with other agencies, case discussion and staff work. The first couple of casework hours are in intake/assessment followed by a maximum of eight hours of short-term treatment. Clients are then usually discharged. Some are resolved in a shorter time, but some are transferred to a longer-term follow-up program.

All staff must schedule 40% of their time on the Intake/STT program and 60% on other work. For a full-time employee this means about eight hours of client contact per week in this program, plus about eight administrative hours, which copes with about one new client each

week and about eight ongoing short-term cases. The other 60% includes the long-term cases, specialty programs or discipline-specific tasks such as psychometric testing, and agency tasks such as consultancy to other agencies.

This plan is based on research showing that about 70% of cases will be successfully treated in the short-term timeframe, which consumes about one third of available staff time. The other 30% take much more time but this method avoids the 70% having to wait long periods before they are seen. It is analogous to the Supermarket Express Checkout.

The method, however, is not a solution for under-resourced services. As one full-time staff member can maintain a throughput of about one new case per week, a referral rate of five new cases per week will need five staff members to maintain quality service. If there are not enough staff members to meet this demand, the quality of the service will be sacrificed in one way or another. Either the long-term treatment and support would have to be curtailed or case referrals refused (the traditional waiting list did this by making people wait so long that they went elsewhere in a state of considerable dissatisfaction with the poor quality of service). One psychiatrist in private practice resolved this by making assessments of all referrals but immediately sending most of them back, untreated, to the referring agency with recommendations about further management. Clients are generally unhappy with that solution and the preferred management is for cases to be assessed and treated by the clinician of first contact.

Intake is best undertaken by experienced caseworkers. This is because the initial session lays the groundwork for the therapeutic contract, generally offering the greatest opportunity for establishing trust and rapport, and an indication of whether the problems can be dealt with by brief intervention or will require an extended treatment program. This advantage is lost when the intake worker is insufficiently skilled, particularly if the case needs to be transferred to another worker for treatment.

Intake interview needs to cover:

- A summary of the issues of concern and the client's rating of their severity
- A genogram of the client family including psychosocial histories of members
- A description of the social circumstances of the client family

If the Networker is experienced, the intake and assessment processes can be seamlessly merged, and a conclusion reached as to whether the treatment is likely to be achievable in short-term intervention or that longer term arrangements must be made. If it is to be short-term, the experienced worker can continue with the case already engaged. If it is not likely to resolve with short-term treatment it is not seen in the short-term program but seen in the longer-term program.

If there is no trained and experienced Intake worker it is still possible for a novice to gather the necessary information, but it is preferable for it to be done using structured and standardised instruments such as the Achenbach Child Behaviour Checklist, the Family Assessment Device and (in the case of adolescents) the Youth Self-Report Checklist. In this way the novice gains experience and the necessary information is available for monitoring by supervising staff. A novice should not make treatment decisions unless under supervision.

The assessment needs to additionally cover:

- Mental state appraisal of relevant family members
- Family function appraisal
- Commitment of the family for a therapeutic process

At the end of assessment, a case-formulation and <u>management plan</u> should specify:

- The nature and extent of the problems perceived by clients and therapist
- The supposed predisposing, precipitating and perpetuating reasons for the problems
- The changes acknowledged by clients to resolve their problems (treatment goals)
- The treatment plan agreed with clients to bring about those changes (therapeutic contract).

The treatment may be in the short-term program (if it is anticipated that the goals can be achieved in that timeframe) or in appropriate longer-term support and treatment where necessary. The latter includes referral to other agencies.

The issues of concern and the extent of achievement of treatment goals of all clients should be periodically reviewed and recorded. This self-monitoring is essential for quality improvement and for evidence of effectiveness. This is needed for advocacy and funding submissions. "Evidence-based programs need program-based evidence, and this is how you get it".

This is a model developed for CAMHS. It needs to be evaluated for application to adult MHS, AOD services, and other agencies.

<u>Part 4.6</u>: Crisis response and long-term stays

This is the part of the mental health system that I have had least involvement and try to avoid in my clinical work. I am quite prepared to see people who are severely disturbed, especially when they have made a pledge to themselves and others that they do not want to go back to hospital. The current set of responders, whether a Crisis Assessment Team or an inpatient facility, are not easy to access and are usually not available at the point of crisis, except for extreme cases, when the Police attend, as well, anyway.

Some people do need crisis intervention requiring immediate hospitalization. Some people need long-term stays to address the complexity of their troubles. It is hard to plan for services that have intermittent use and limited bed space. Yet, such facilities are needed. It is probable the planning will have to include the prospect of empty beds on a regular basis. Flexible employment practices will need to be designed that draw upon experienced nurses to provide quality patient care to inpatients when needed and use other parts of their time in community education, or with intake functions.

How such work might be practiced needs to be considered by experienced practitioners. It is a function of mental health services that will not disappear with the coming online of preventive and early interventive programs. The cost of such inefficiency needs to be funded and seen as a research and development function.

Initiative 5: Active facilitation of collegiality

Collegiality, integration, and coordination need to exist in all cases to ensure adequate responses to each of the five components and in a way that makes sense within the lives of the family being treated. Contributions need to be drawn from all professionals involved, whether public or privately employed, and the consumer and carers. Rarely should consumers and carers be excluded from meetings. Meetings should not be another opportunity for direct client work. The GP clinic may often be the best venue, but Medicare items will be needed to ensure regular planning of case conferences, including items for travel to and from such meetings.

Another means of facilitating collegiality is through the scheduling of shared training events on topics of mutual interest and clinical pertinence. These may be organized through the Primary Health Care networks.

Thirdly, case studies of successful collaborations should be documented. It may be useful to document cases of failed collaborations, as well.

The case conferences need to be forums where the rights of the child and the rights of the consumer are taken seriously and actively reviewed.

Recommendations

Implementing the five initiatives, as described, will contribute to prevention, early intervention, and effective crisis response from the outset and would be refined over time as experience is accumulated and training provided. Short-term inefficiencies will arise as new systems are developed and implemented. Stopping cycles of intergenerational transmission of trauma and the drawing upon the resources of the wider family and community will create efficiencies into the future.

References

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