WITNESS STATEMENT OF GAIL BRADLEY

I, Gail Bradley, Interim Operations Director, of 1-North, Royal Melbourne Hospital, Grattan Street, Parkville, in the State of Victoria, say as follows:

1 I am authorised by Melbourne Health to make this statement on its behalf.

2 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

Please outline your relevant background including qualifications and relevant experience.

3 I am a clinical psychologist with the following qualifications:

(a) Bachelor of Behavioural Sciences (Hons);

(b) Master of Psychology; and

(c) Graduate Diploma of Business – Organisation Change and Development.

4 I have approximately 32 years of experience working in public mental health services across the north and west of Melbourne, 25 years of experience in operational leadership roles and 10 years of experience in private practice. Attached to this statement and marked **GB-1** is a copy of my Curriculum Vitae.

5 I have been an employee of Melbourne Health since 1995 and have been in a variety of operational leadership roles within it:

(a) from 1995 to 2010, I was the Program Manager of Continuing Care Services, Inner West Area Mental Health Service (**Inner West**). This involved the management of 3 community mental health teams and a multi-disciplinary team of about 58 staff. The teams were the Continuing Care Team, Homeless Outreach Psychiatry Service (from 1999) and the Primary Mental Health Team (from 2001);

(b) between 2003 and 2010, I was the Senior Psychology Advisor of NorthWestern Mental Health (**NWMH**). This involved professional oversight of a workforce of over 100 psychologists within the NWMH Program;

(c) I was the Area Manager of Inner West from November 2010 to February 2019, and I will be resuming this role in July 2019;

(d) I have been the Interim Operations Director of NWMH since February 2019 and was also acting as the Operations Director between January and March 2014.

6 In addition to my current role, I have been in private practice since 2009 at the Glencairn Consulting Suites and a performance assessor of psychologists since 2011 at the Australian Health Practitioners Regulatory Board.

Please describe your current role and your responsibilities, specifically your roles as Interim Operations Director at NWMH and Inner West Area.

7 As the Interim Operations Director, I am responsible for the effective and efficient operations management of NWMH (including financial management and strategic direction) in conjunction with the area and program managers. This includes overseeing consumer access to mental health services, human resources and occupational health and safety processes and infrastructure programs within NWMH, developing collaborative partnerships and performance reporting.

8 As Area Manager of Inner West, my responsibilities are similar to that as Interim Operations Director but only in respect of Inner West.

NWMH

What is NWMH and what services does it provide?

9 NWMH is a clinical division of Melbourne Health and operates in partnership with Northern Health and Western Health.

10 NWMH has a multi-disciplinary workforce of 1,900 and provide services through six services:

(a) a Youth Mental Health Service (Orygen Youth Health Clinical Program);

(b) four adult Area Mental Health Services (**AMHS**): Inner West (Cities of Melbourne and Moonee Ponds), Mid West AMHS (Cities of Brimbank and Melton), North West AMHS (Cities of Moreland and Hume) and Northern AMHS (Cities of Darebin and Whittlesea); and

(c) an Aged Persons' Mental Health Program.

11 There are 32 sites from which services are delivered. Each service is similarly structured, except for some variations in Orygen Youth Health Clinical Program and the Aged Persons Mental Health Program.

12 The Orygen Youth Health Clinical Program is a unique, youth-specific early intervention mental health service that provides a range of time-limited services to young people aged 15 to 24 years who live within the catchment areas of 3 of NWMH's 4 adult AMHSs (being North West AMHS, Mid West AMHS and Inner West AMHS) or the catchment area of South West AMHS (which is part of Mercy Health and is outside NWMH's adult catchment areas).

NWMH's services

13 In summary, NWMH's services are as follows:

(a) young people (15 to 25 years): specialised youth clinical mental health service, integrated training & communications program, and Forensic Youth Mental Health Service;

(b) adults (18 to 65 years): Acute Inpatient Units, community teams, Community Care Units, Emergency Mental Health and Prevention & Recovery Care;

(c) older people (65 years and above): Inpatient Units, Aged Psychiatry Assessment & Treatment Teams, Behavioural Assessment and Specialist Intervention Consultation Service, Intensive Community Treatment and Residential Services; and

(d) speciality and regional services: Triage, Adult Mental Health Rehabilitation Unit, Dual Diagnosis (Substance Use and Mental Illness Treatment Team (**SUMITT**)), Eating Disorders Program, Neuropsychiatry Unit, Private Consulting Suites, Second Psychiatric Opinion Service, Victorian Centre for Excellence in Eating Disorders, and Forensic Interface Team.

14 NWMH's key services include the following:

(a) Acute Inpatient Units (**AIU**): provide specialist treatment for people experiencing an acute episode of mental illness who require treatment and care in a hospital in-patient unit setting. There are a total of 203 beds in NWMH's AIUs (133 beds in Adult AIUs, 54 in Aged AIUs and 16 in Youth AIUs).

(b) Community Teams: multidisciplinary teams that provide community based assessment, treatment and case coordination. This includes short-term treatment for people experiencing an acute episode of mental illness, and longer-term treatment, rehabilitation and support for people with severe mental illness who are living in community settings (including supported accommodation). Specialist interventions are provided in the domains of Psychological Interventions, Family and Carer Work, Health & Wellbeing, Vocation, Lived Experience and Overcoming Hurdles. Secondary consultation is also provided to people of all ages with high prevalence mental health disorders who are receiving treatment or support from a General Practitioner (**GP**) or Community Health counsellor.

(c) Community Care Units (**CCU**): provide treatment and rehabilitation for people with serious mental illness and psychosocial disability, in a community-based residential setting, with 24-hours nursing support. The aim of the CCU is to equip individuals with the daily living skills they require to live independently. There are 20 beds in CCUs per adult Area Mental Health Service.

(d) Emergency Mental Health Teams (**EMH**): clinicians are located in the emergency departments (**ED**) of the Royal Melbourne, Northern and Sunshine hospitals where they provide assessment and consultation services for patients presenting with suicidal and self-harming behaviours. Under the Police, Ambulance and Clinical Early Response (PACER) program, EMH clinicians also work with local police in a joint response to provide such services to those in the community.

(e) Prevention and Recovery Care (**PARC**): a supported residential service for people experiencing a significant mental health problem but who do not need or no longer require a hospital admission. PARC services are a partnership between NWMH and Mental Health Community Support Services, and aim to assist in averting acute inpatient admissions and facilitate earlier discharge from AIUs. Each PARC comprises 10 beds. There are two new PARCs in development – a 12-bed PARC for women with capacity for 3 young dependents, and a 20 bed PARC for youth.

Redesign of adult community services

15 In relation to its community-based mental health services, NWMH commenced a major reform process in 2013. The Adult Community Program Redesign (**ACPR**) aims to improve the clinical outcomes and the experiences of individuals and their families or carers by redesigning the specialist care, treatment and support provided by NWMH in community settings. Prior to the ACPR, service delivery was centred on pharmacological treatments, multiple assessments and case management. Particular drivers for the ACPR were:

(a) feedback from consumers and family or carers that they are not being heard and not being sufficiently informed about the consumers' care;

(b) silos and fragmentation between and across services, creating duplication and inefficiencies;

(c) increasing demand and static capacity;

(d) workforce issues, including loss of senior staff, an acuity-focussed staffing system, and lack of ability to utilise specialist skills; and

(e) inconsistent provision and access to evidence informed care across the mental health services.

16 The objectives of the ACPR are to:

(a) provide evidence-based care to consumers and their family or carers;

(b) provide seamless, appropriate and acceptable services to consumers and their family or carers; and

(c) make best use of available financial and human resources to meet the challenges of increasing service demand.

17 To implement the practice reform across NWMH, a working group made up of NWMH's clinical and academic leaders developed the *Practice Guide – A Recovery approach to our Adult Community Services* dated August 2013. Attached to this statement and marked **GB-2** is a copy of this practice guide.

18 NWMH also has a strong reputation for provision of lived experience programs and a growing peer support workforce which provides post-discharge and community support, participates in recruitment panels and co-designs new services.

Where does NWMH fit within the mental health system?

19 NWMH services a catchment population of 1.4 million people and is one of the largest publicly-funded providers of mental health services in Australia. Its network of mental health services includes 4 of the 21 Area Adult Mental Health Services.

Who receives NWMH's services? What are the criteria for people affected by mental illness to access NWMH's services? Must NWMH's clients come from any particular geographic location?

Access to services

20 People with severe and injuring mental health conditions receive NWMH's services. This includes people who are acutely unwell or require a long time to treat.

21 There are 3 main ways by which people may attempt to access NWMH's services – through EDs, referral from community services, or our triage service. The triage service

is a telephone-based assessment and support service (operating 24 hours, 7 days a week) and is staffed by senior mental health clinicians, a psychiatric registrar and a consultant psychiatrist.

22 The criteria for people affected by mental illness to access NWMH's services include the following:

(a) residence in the catchment area for the particular service (see paragraph 23 below for a list of all catchment areas);

(b) diagnosis of a severe mental illness (for example, schizophrenia spectrum disorders, severe mood disorder, severe eating disorder, severe borderline personality disorder) or presents an acute risk of harm to self or others (for example, risk of suicide, disorientation, poor judgement, hallucinations and hostile and aggressive behaviour);

(c) current symptoms;

(d) ongoing psychosocial disability;

(e) history of hospitalisation;

(f) significant and ongoing risk factors or co-morbid disorders such as substance abuse;

(g) tendency to relapse;

(h) impairment of judgement or disorganisation;

(i) engagement of other health and welfare services significantly; and

(j) circumstances which present difficulties for GPs, private psychiatrists or disability support services to manage.

Catchment areas

23 NWMH's catchment areas depends on the age of the person seeking its services:

Age group	Catchment areas
Young people (15 to 25 years)	Cities of Brimbank, Hobsons Bay, Hume, Maribyrnong, Melbourne, Melton, Moonee Valley, Moreland and Wynham.
Adults (18 to 65 years)	Cities of Brimbank, Darebin, Hume, Melton, Moonee Valley, Moreland, Whittlesea and Melbourne.
Older people (65 and above)	Cities of Banyule, Brimbank, Darebin, Hobsons Bay, Hume, Maribyrnong, Melbourne, Melton, Mooney Valley, Moreland, Nillumbik, Whittlesea and Wynham.

24 In general, a person must reside in the catchment area of the particular service of NWMH to access services. For example, a person trying to access services at Inner

West must reside in the catchment areas of the Cities of Melbourne or Moonee Ponds. There are, however, exceptions – if, for example, a psychotic person who presents a high risk of harm to self and others arrives at the ED of a service, that person may get an AIU bed even if they are not from that service. NWMH may later try to transfer that person to a service in the catchment they reside in.

Does NWMH assist people affected by mental illness with all degrees of severity and complexity? If not, what kinds of providers would meet the needs of those people outside of NWMH's reach? What other parts of the mental health system are your patients likely to use (or want to use)?

25 NWMH does not have sufficient resources to assist all people affected by mental illness with all degrees of severity and complexity.

People with severe mental illnesses

26 NWMH is only able to provide services to some, but not all, people who have severe mental illnesses (for example, schizophrenia spectrum disorders, severe mood disorder, severe eating disorder and severe borderline personality disorder). Due to increased demand for mental health services, it is estimated by our academics that only 30% of people who have such illnesses are able to receive treatment in public mental health services in Victoria.

27 In addition, NWMH is generally only able to provide consumers with episodes of care before referring them out to primary care providers. Such consumers tend to relapse and return to the service for another episode of care, creating a revolving door effect. A typical longer term intervention (**LTI**) episode of care would be from 6 to 12 months – this period is sufficient to help consumers attain a more stable state but is insufficient for recovery that is inclusive of restoration of psychosocial functionality, which typically takes several years. A small group of consumers (about 10%) remain with the service permanently due to ongoing risk and treatment resistant symptoms.

28 A related issue is that our staff members do not experience as much work satisfaction because consumers tend to get discharged before attaining full recovery.

People with milder forms of severe illness or high prevalence disorders

29 There is very limited capacity to accept people with milder forms of severe illness, or with high prevalence disorders (for example, depression or anxiety) with acute presentations, for a standard LTI episode of care. Such people may be accepted if, for example, they present a risk of harm to self or others (for example, risk of suicide, disorientation, poor judgement, hallucinations and hostile and aggressive behaviour).

30 Following the ACPR, however, the targeted brief intervention (**TBI**) was introduced in NWMH's four Area Adult Mental Health Services to cater for such people by supporting primary care providers. The services would provide each person with a thorough assessment, single session family consultation to identify required family supports, physical health assessment, vocational assessment, and then refer them to the GP or private practitioner with recommendations for ongoing treatment. A typical TBI episode would take 4 weeks and may be extended in some instances to up to 3 months if could benefit from a group program such as Wise Choices.

Other providers

31 The primary care providers are mainly GPs or private psychologists through the federal government's *Better Access* initiative, which provides Medicare rebates to individuals diagnosed with a mental health disorder for up to 10 treatment sessions with a private psychologist per calendar year. There is huge demand for private practitioners with expertise in mental health but 10 sessions per calendar year is usually insufficient to provide the appropriate level of support to people with enduring and relapsing conditions. Also, some consumers may not be able to afford gap payments despite the rebates. Nevertheless, for those who can manage their mental illnesses with 10 sessions per calendar year but require ongoing support, the *Better Access* initiative is generally able to provide them with access to psychological services in the long term.

32 If people affected by mental illness have the financial resources, they may seek help from private psychologists or psychiatrists.

Other parts of the mental health system

33 EDs are part of the mental health system. There has been a very significant increase in people seeking to access the mental health system through EDs, which are not the appropriate setting for assessing them.

34 Mental Health Community Support Services (**MHCSS**) were also a part of the mental health system. The Department ceased the funding of them 18 months ago because it was anticipated that the National Disability Insurance Scheme (**NDIS**) would provide an alternative form of psychosocial support, but this has not proven to be the case. The NDIS can assist consumers in relation to functional areas such as cleaning and garden maintenance, but does not allow the employment of workers with the capacity to provide psychosocial support. In recognition of this gap, however, the Department has initiated a tender process for MHCSS providers under the Early Intervention Psychosocial Support Response which is currently funded for 2 years.

Briefly, how is NWMH funded?

35 NWMH is block funded by the Department of Health and Human Services (**Department**) through Melbourne Health.

36 Funding is secure but we often have to tender for any new programs or developments, which results in piecemeal resourcing. For example, there was a recent tender for a program to support people with personality disorders but the funding was only for 1 equivalent full-time position (**EFT**) within NWMH.

INNER WEST

What is Inner West and what services does it provide?

37 Inner West is an adult Area Mental Health Service for people living in the Cities of Melbourne and Moonee Valley.

38 Inner West's key services include those set out in paragraph 14 above, as well as the following:

(a) <u>Consultation-Liaison Services</u>: the diagnosis, treatment and prevention of psychiatric illness among physically ill patients who are patients of an acute general hospital. This includes the provision of psychiatric assessment, consultation, liaison and education services to non-psychiatric health professionals and their clients/patients.

(b) <u>Neuropsychiatry Unit</u>: a state-wide specialist mental health service that offers neuropsychiatric assessment and advice to psychiatric, neurological and other medical and mental health services. The service is provided by the Royal Melbourne Hospital Neuropsychiatry Unit, a clinical unit of the Melbourne Neuropsychiatry Centre, which is a joint centre of Melbourne Health (NWMH) and the University of Melbourne (Department of Psychiatry).

(c) <u>Eating Disorders Unit</u>: a service catering for NWMH's catchment areas for adults and the north-west rural area. It includes an 8-bed inpatient unit, a day patient program, and an outpatient service.

Where does Inner West fit within the mental health system?

39 Inner West is one of Victoria's 21 AMHSs.

Who receives Inner West services? What are the criteria for people affected by mental illness to access Inner West's services? Must Inner West's clients come from any particular geographic location?

40 Inner West's consumer group and criteria for access are the same as that of NWMH (see paragraphs 20 to 22 above), save for the following:

(a) Inner West's catchment areas are the Cities of Melbourne and Moonee Valley;

(b) Inner West has a large proportion of homeless consumers in the City of Melbourne. These consumers are either rough sleeping in the Central Business District (**CBD**) or in the two crisis accommodation services for men within the catchment area (Flagstaff and Ozanam House). A history of homelessness is common in patients with psychosis using inner urban mental health services and is associated with poorer engagement with psychiatric services. Attached to this statement and marked **GB-3** is a copy of an article I co-authored on this topic;

(c) Inner West has a large proportion of consumers with forensic issues, partly because the Melbourne Assessment Prison is in our catchment areas and directs people affected by mental illness to Inner West service upon their release. These issues often co-occur with homelessness and substance use. There is a need for the development and evaluation of preventive psychosocial forensic interventions in mainstream adult community mental health services. Attached to this statement and marked **GB-4** is a copy of an article I co-authored on this topic.

Does Inner West assist people affected by mental illness with all degrees of severity and complexity? If not, what kinds of providers would meet the needs of those people outside of Inner West's reach? What other parts of the mental health system are your patients likely to use (or want to use)?

41 Paragraphs 25 to 34 above apply to Inner West as well.

Briefly, how is Inner West funded?

42 Inner West receives a portion of the block funding received by NWMH.

RUNNING AN AREA MENTAL HEALTH SYSTEM

In your experience, in relation to the needs of people affected by mental illness for clinical treatment:

Is supply keeping up with demand? What gaps have you observed?

43 No, supply has not been keeping up with demand (see paragraphs 26 to 30)

44 Gaps that I have observed include the following:

(a) an emphasis on culturally responsive services has eroded. This is particularly evident in the area of services for Aboriginal and Torres Strait Islander people – there is a lack of Aboriginal Health Liaison Officers or mental health staff of indigenous background;

(b) there are no services for people with comorbid Autism Spectrum Disorder or other developmental conditions;

(c) there are insufficient resources and capacity to work with people with comorbid Alcohol and other Drugs (**AoD**) issues or forensic issues. Inner West has employed blended expertise (having both AoD and mental health expertise) into each of our Community Teams but that is not reflective of all AMHSs. We also have the Substance Use and Mental Illness Treatment Team (SUMITT) program, but it is insufficiently resourced (0.3 EFT) given that about 40% of consumers use substances in addition to having a mental illness;

(d) there is a lack of inpatient bed access (see paragraphs 48 to 52). Relevantly, there is significant population growth but infrastructure has not caught up – this issue is particularly prevalent in the past 3 to 5 years. There has been limited funding across the State, with almost no investment in the mental health system for almost a decade (save for some very modest growth funding in the last 3 years);

(e) the consumer and carer peer support workforce is slowly developing and provides a very important service, but it is insufficient in number and lacks well-developed supervisory and mentoring support structures.

If there is unmet need, what needs are the most critical?

45 The following needs are the most critical:

(a) the need to provide services to a larger proportion of the group of people with severe and enduring conditions for longer periods of time. As discussed above, only 30% of such people receive treatment at public mental health services, and episodes of care are insufficient to allow lasting recovery. Inner West has sought to alleviate this need by integrating our Crisis Assessment and Treatment Teams (**CAT Teams**), Mobile Support and Treatment Teams (**MST Teams**) and Continuing Care Teams into 3 Community Teams and redistribute resources (see paragraphs 80 to 81 below). While this created more manageable caseloads for LTI episodes of care (from 38 to 18 per clinician), this has only supported management of Inner West's existing caseloads, and has not allowed greater access to services. In other words, access is still restricted to 30% of people with severe and enduring conditions;

(b) the need to support people who attend EDs with suicidal presentation. We have the 'Engage' program, which is attached to the ED and provides follow-up support to people who have attended the ED with mental health crisis and suicidal presentation. Due to assessment demands, however, the staffing for this role has mostly been redirected to assessment work;

(c) the need to provide evidence-based, psychosocial interventions (in addition to pharmacological interventions) that prevent the current revolving door phenomenon of people coming in and out of treatment, achieve real change, and create potential for a life that is worth living. These interventions are holistic and effective, but there is limited capacity of mental health services to provide them and where they are provided, they are not provided at the frequency or duration of treatment required to achieve change. I have elaborated on these interventions at paragraphs 87 to 93 below;

(d) the need for additional beds to enable treatment of more people needing acute support, and enable the community workforce to more effectively treat people and reduce risks of relapse.

What are the key drivers of unmet need?

46 The following are key drivers of the unmet needs:

(a) population growth;

(b) inadequate funding of public mental health services over an extended period of time (as explored in the Victorian Auditor-General's Office's audit report on *Access to Mental Health Services* dated March 2019);

(c) increased social disconnection and family breakdown;

(d) erosion of community support services (for example, housing programs and consequent housing insecurity);

(e) difficulties of people affected by mental illnesses to obtain employment, stable income and financial security; and

(f) people affected by mental illnesses feeling hopeless, contributing to increased rates of substance use and dependence.

What kinds of impact does unmet need have on people affected by mental illness?

47 If people affected by mental illness are not treated, this leads to further deterioration of their illness, social disconnection, substance use and an increased risk of violence.

Are there enough beds to service demand for acute need? If not, why not?

48 There are not enough beds to service demand for acute need.

Quantity of beds

49 There are currently 203 AIU beds at NWMH:

Adult AIUs	**Bed Type**	**Total**
John Cade Unit. Royal Melbourne Hospital	21 Low Dependency (**LD**) + 8 Intensive Care Area (**ICA**)	29
Northern Psychiatry Unit 1. The Northern Hospital	20 LD + 5 ICA	25
Northern Psychiatry Unit 2. The Northern Hospital	20 LD + 5 ICA	25
Sunshine Adult Psychiatry Unit. Sunshine Hospital	21 LD + 8 ICA	29
Broadmeadows Inpatient Psychiatry Unit. Broadmeadows Health Centre	20 LD + 5 ICA	25
Sub Total (Adult Acute Beds)		**133**
Youth AIUs	**Bed Type**	**Total**
Orygen Inpatient Unit. Western Hospital Campus	16 LD	16
Sub Total (Youth Acute Beds)		**16**
Aged AIUs	**Bed Type**	**Total**
Sunshine Aged Acute Inpatient Unit. Sunshine Hospital Campus	20	20
Broadmeadows Aged Acute Inpatient Unit. Broadmeadows Health Centre	19	19
Kath Atkinson Wing Aged Acute Inpatient Unit. Bundoora Extended Care Centre	15	15
Sub Total (Aged Acute Beds)		**54**
Total Beds		**203**

50 NWMH's current bed stock provides 1.65 adult beds per 10,000 adult population, which may be compared to another Melbourne metropolitan service (Alfred Psychiatry) which provides 2.6 beds per 10,000 adult population. To meet the actual need for acute service support, it is estimated that 3 beds per 10,000 population are required. Acute mental health presentations are also growing at an annual rate of 2.4%, creating an increasing need for beds.

51 There are also insufficient ICA beds. Currently there are 31 ICA beds out of the total 149 youth and adult acute beds which are always full. Each morning, NWMH typically needs to admit 4-6 consumers into ICA beds, which means prematurely moving 4-6 consumers who are only marginally less acute out of ICA.

52 NWMH has up to 18 people in conference calls twice every day to manage bed stock and prioritise demand, and there are permanently employed staff in each service to manage bed access. For example, if we have people interstate or from another catchment area in our unit, we will try to send them to their catchment area.

Length of stay

53 Demand pressure has led to length of stays that are far less than needed, and premature discharge increases risk of readmission. The length of stay at NWMH has trended down from 14.7 days to 11.2 days from 2009 to 2017, and was 9.6 days in 2017-2018. For Inner West, the most recent performance report indicates an average length of stay of 9.1 days.

Design of units

54 Each AIU has mostly ensuite bedrooms, a lounge area, an activities area, and a dining room. The bedrooms can be locked but staff can access them.

55 The ICA unit of Inner West is not well designed for its purposes. For example, there is no segregation of male and female areas, and there is only small lounge. Ideally, there should be separate common areas.

56 Inner West's low-dependency unit has separate common areas for men and women and separate bedroom corridors, but not the ICA unit where it is most needed.

Delivery of programs

57 Due to the constant need to manage high acuity, stretched staff struggle to maintain high quality, therapeutic programs such as Safewards which have demonstrated improvements in the experience of care for consumers in inpatient units.

In your experience, are clinical mental health services crisis driven? If so, in what respects and why?

58 Clinical mental health services are increasingly crisis driven.

Access to services

59 The lack of investment in services alongside extensive population growth and growth in service demand has resulted in a very high threshold of risk for acceptance to community treatment, with about 30% of individuals with severe and enduring mental illness accepted into public mental health services.

60 Mental health presentations at EDs are increasing at a rate of 7% per annum, year on year. Acute mental health presentations are also growing at an annual rate of 2.4%.

61 NWMH's centralised triage service has experienced increased demand and has insufficient resources to meet that demand. There are long waiting times and high call abandonment rates, contributing to direct presentations to EDs.

62 In addition, outreach capacity (that is, the capacity to visit consumers in their homes) has diminished significantly, and the capacity to provide rehabilitation across a spectrum of bed-based services has evaporated.

Treatment

63 The lack of resources has also resulted in:

(a) a re-focus of treatment to acute presentations of mental distress; and

(b) the prominence of pharmacological treatments and minimal provision of psychosocial treatment.

64 Brief "episodic" care and rapid referral out to primary care and private services (for those who can afford it) has become the norm, which does not match the need for ongoing treatment and support required for treatment of severe mental health conditions, especially those with a frequently relapsing course. Attached to this statement and marked **GB-5** is a case study which demonstrates the impact of episodic community care on one of Inner West's consumers.

65 People who are well enough to engage in the range of programs that have been developed are generally not eligible for service (intake) or are rapidly referred to external providers to make room for more acutely unwell people coming through the door. Hence, there is little capacity to make lasting change.

Inner West

66 At Inner West, there is a strong vision and development of programs to support consumers in their recovery, prevent future relapse and disruptive sequelae (loss of employment, hopelessness and risk of dependence on alcohol and other drugs). We are moving towards much more effective treatment, but crisis demand continues to disrupt recovery work.

What treatment is available for people who do not meet the criteria for treatment at the service? What are the barriers to people receiving appropriate treatment, from a systems perspective?

67 Please refer to paragraphs 29 to 31 for the options available for people who do not meet the criteria for treatment at Inner West.

68 From a systems perspective, the key barriers to people receiving appropriate treatment are essentially:

(a) the lack of an appropriate holistic model of evidence-based care and implementation strategy; and

(b) insufficient funding to ensure longer term recovery work is undertaken in a consistent manner.

69 These key barriers are inter-related. To support the shift in focus to, and the implementation of, evidence-based practice, services need greater funding to enable necessary changes to their workforce and accountability structures (see paragraphs 108 to 111 below). Funding would also enable people to be treated with evidence-based practice for the period necessary to achieve recovery that is inclusive of restoration of psychosocial functionality.

70 In relation to funding, a related barrier is that annual block funding does not increase in line with the Consumer Price Index (**CPI**) increases resulting in a lower budget from which to fund the service. Furthermore, the Department provides limited capital funding, so any infrastructure needs (for example, leasing buildings, repairs to buildings) must come from funding for staffing resources. This then impacts the amount of funding available to employ staff.

If a person has a chronic mental illness but are not in "crisis" where do they go for immediate support?

71 There is very little available for people in this situation. They may seek family support, which adds to carer burden in the absence of professional supports. Those with social networks use these, but can burn out friendships leading to further community isolation. A very few are connected to churches and use connections there. Some engage alternative healers (for example, clairvoyants and naturopaths) which can create further problems as they are not professional support for mental illnesses.

Do you have experience of the "missing middle" – people whose needs are too complex for the primary care system alone but who are not sick enough to obtain access to specialist mental health services?

72 Yes, this group are likely to consult GPs or private psychologists through the federal government's *Better Access* initiative (see paragraph 31 above). A large number of this group end up in the private consulting suites I work at, Glencairn Consulting Suites, which is co-located with the North West AMHS. I am confident that similar clinics also provide services to this group.

73 Previously, AMHSs were able to cater for a larger range of people, from those with complex, high prevalence disorders and low income whose needs are too complex for GPs up to those with severe mental illnesses. Due to the increased demand for mental health services, however, AMHSs have shifted their focus almost exclusively to low prevalence disorders.

How does the complexity of the mental health system (variability between geographic areas, overlaps/duplications between different levels of government, and gaps) impact on people's ability to access services and navigate the system? What tools are in place currently to help people navigate the system? How effective are they?

Complexity

74 I think it can be very overwhelming and distressing for people, especially if they are new to services, and there is very little built into the mental health system to assist with service navigation. It is also confusing for the staff working in the system.

75 As Inner West's catchment areas includes the City of Melbourne which has a large number of homeless people in the CBD, we often liaise with Victoria Police regarding homeless people. This is complicated because the police have different geographic areas within the CBD and it is unclear with which police station we should liaise.

76 Local government areas also have boundaries but Inner West does not have an issue with navigating these areas.

Tools in place

77 There are not many tools currently in place to help people navigate the system.

78 Most information is provided over the phone by triage workers, who have been effective in directing people to services in their catchment areas but are inadequately funded. Triage workers also tend to make recommendations to people in crisis to attend their local ED because that is the easiest way to get into a mental health service. This has

probably contributed to the large increase in mental health attendances at EDs over the last 5 years (increasing at a rate of 7% per annum, year on year, with an increase rate of 9% in 2015-16).

79 NWMH has developed a web page which is informative, but I am not sure how user-friendly it is for people. Inner West also has a peer support program that may help people navigate the system. Under this program, we employ peer support staff who have lived experience to work in our Community Teams and support consumers. This has been very popular with both consumers and carers.

How do your services deliver community-based care?

Integrated Community Teams

80 As part of the ACPR, Inner West has merged its CAT, MST and Continuing Care Teams to develop 3 integrated Community Teams where all required elements of acute and recovery care programs are provided within each team, and generally consistently by the same clinicians (for example, nurses, psychologists, social workers and occupational therapists). These clinicians work in collaboration with medical professionals.

81 All required elements of acute and recovery care programs are provided within each team, and generally by consistent clinicians. Integration has reduced reassessment and silos, difficulties of consumers and carers with navigating the system, as well as average case load from 38+ to 18 consumers per full-time clinician. Integration also allows the Community Teams to have capacity to implement psychosocial interventions that make a difference and provide greater quality of care.

82 One of the three Community Teams is the homeless team, which works on an outreach basis from the Royal Melbourne Hospital. The homeless team provides the full range of TBI and LTI services to homeless people, and manages their needs for acute care and admission to hospital.

83 Another function of the integrated Community Teams is the Assisted Intensive Medication Service (**AIMS**), which was developed in 2010. AIMS is an evening (5 pm to 9 pm) outreach support program which provides a home-based, supplementary, recovery and self-management focussed medication adherence support service. AIMS is staffed by 2 teams of 2 enrolled nurses and one senior community nurse, and delivers to consumers phased support (from intensive support through multiple visits per week through to independence). Interventions include motivation interviewing, cueing and other behavioural support interventions.

84 AIMs has demonstrated significant reductions in relapse rates, re-admission rates (from 92 in the 18 months before AIMS was introduced, to 53 in the 18 months after AIMS was introduced) and bed costs (from $1.5 million to $663,000 over the same periods). It also won a Victorian Health Care award in 2016.

Evidence-based psychosocial interventions

85 Treatment by Inner West's Community Teams is delivered in line with the ACPR model with LTI, TBI and consultation services as the core elements.

86 The consumers who receive treatment from our Community Teams are frequently referred from our AIU. There is a small proportion of consumers who are not responsive to community-based treatment and require assertive outreach. These include, for example, a small group of compulsory patients under the *Mental Health Act 2014* (Vic) who refuse to attend our service for treatment and may be brought into hospital by the police and a clinician for administration of long-acting medication through an injection. We do not currently have a suitable space for this activity, as it is disruptive to the ward environment. It is also very time consuming to arrange this activity.

87 We reformed our model of care to change our focus from an exclusive case management approach (which has only been shown to improve consumers' access to services, but has not been shown to reduce relapse rates or improve quality of life) to the use of evidence-based psychosocial treatments across 6 practice domains to provide more psychosocial -focused and holistic care. Attached to this statement and marked **GB-6** is a summary of these treatments. Also attached to this statement and marked **GB-7** is a slide deck I prepared on how mental health services can be transformed for the delivery of evidence-based psychosocial treatment.

88 The 6 practice domains for evidence-based psychosocial treatments are Psychological Interventions, Family and Carer Work, Health & Wellbeing, Vocation, Lived Experience and Overcoming Hurdles. Each practice domain has both core and specific interventions. Attached to this statement and marked **GB-8** is a list of the specific interventions for each practice domain, with brief descriptions of each intervention.

89 The following are examples of how these interventions work:

(a) Psychological Interventions: The Early Warning Signs Relapse Prevention Program is a brief individual program (6 sessions) to help consumers self-manage their mental health by identifying the very first warning signs of relapse. There is strong evidence that this program significantly reduces relapse admission rates (from 65% in the 18 months prior to the program to 18% in the 18 months following the introduction of the program). Attached to this statement and marked **GB-9** is a case study of one of Inner West's consumers who engaged well with this program and has not relapsed since completing it;

(b) Family and Carer Work: The core intervention involves the Community Team getting in contact with the consumer's family within the first 6 weeks of contact with the consumer. During that contact, the team offers a Single Session Family Consultation to the family. Other specific interventions may be introduced. Such interventions have resulted in a significant reduction in relapse rates and help to reduce the stress on family and carers. For example, the Multiple Family Group treatment is delivered to up to 7 families including the consumer on a fortnightly basis over 9 months, providing psychoeducation, social support and collaborative problem solving. Attached to this statement and marked **GB-10** is an article, of which I was the primary author, on a randomised control trial that demonstrated how the Multiple Family Group treatment resulted in reductions in relapse and symptoms;

(c) Health and wellbeing: There is generally pre-mature morbidity among consumers. We have a large range of activities and health related groups (for example, the walking group and the swim/gym group) to promote physical health along with mental wellbeing. These have proven to be very popular with consumers and have provided social connection opportunities;

(d) Vocation: It was previously identified that Inner West had a very low employment rate (12%) amongst its consumers. As such, we recruited an employment consultant who has been able to assist 30 consumers to find paid employment, and another 25 consumers to enrol in volunteer or training programs. There has been good feedback from consumers, many of whom would not have considered employment otherwise;

(e) Lived experience: Consumers in our AIU are able to engage with a peer support worker. There are also programs such as Peer Zone, a peer-support and recovery education initiative which provides a series of up to 20 three hour peer-led workshops, and Kick Butt, a peer-led support program for people wishing to stop smoking.

90 We have also significantly developed group programs in the service to support social connection within skill-building programs.

91 All consumers coming into the service are expected to have the opportunity of exposure to the core interventions in each practice domain within the first 3 months of treatment, following which specific interventions are offered that are relevant to their specific needs.

92 We have employed different staff types to support the practice domains (for example, employment consultant, exercise physiologist, dietician, yoga instructor and music therapist). We are currently seeking to recruit an Aboriginal mental health clinician.

93 While evidence-based psychosocial treatments are effective, it is a struggle to deliver the treatments during episodes of care of 6 to 12 months which are generally insufficient for lasting recovery.

How do CAT/ACIS teams work? What are the resourcing challenges with operating a CAT team? If there are barriers to their effectiveness, what are they?

94 Inner West subsumed the CAT Team function into the integrated Community Teams and have a rotating roster whereby each of the 2 Community Teams based at Waratah in Moonee Ponds provides the acute community function on alternate weeks. Two clinicians from the team that is on duty for the week are rostered over 2 shifts – the morning shift from 8.30 am to 5 pm, and from 1 pm to 9.30 pm – for 7 days per week. Police are sometimes needed when the clinicians on duty respond to a request.

95 All referrals for acute assessment and treatment during the week are handled by the Community Teams to maximise continuity of assessing clinicians with ongoing work after the acute phase. These referrals include new referrals from our centralised triage service and internal referrals for after-hours support from other Community Teams within our service (often after receiving concerns from carers).

96 Team integration has led to reductions in time lost during periods of low demand for the CAT Team function during the day, greater efficiency in providing the function, and an improvement in work culture.

What are the critical things that contribute to the success of NWMH and Inner West?

97 The following are critical things that contribute to the success of NWMH and Inner West:

(a) we have a clear vision and committed staff (including senior leadership), which allows us to have the opportunity to develop large scale best practice initiatives;

(b) there is a huge "brains trust" within NWMH (being a large aggregated health service), enabling the development of the ACPR with input from wide range of very experienced clinicians and academics;

(c) Inner West uses a well-developed and comprehensive reliability methodology. The methodology is from Advisory Board, an American-based company that helps organisations improve the reliability of their system. Training on this methodology was provided for all senior managers within Melbourne Health;

(d) we have effective accountability structures to support practice change through the ACPR. The objectives of the ACPR are embedded in all areas of our practice. For example, operational leaders within each Community Team and consultant psychiatrists have to report on a quarterly basis on how they are progressing on the 6 practice domains of evidence-based psychosocial treatments (as opposed to reporting on more general operational and clinical matters). We also have a well-developed system for collecting data on the provision of core and specific interventions by staff, and report this on a monthly basis at staff meetings to ensure visibility of our service direction;

(e) the Director of Clinical Services and I meet with the manager and lead consultant of each Community Team on a quarterly basis to monitor their progress in delivering evidence-based psychosocial interventions (including progress in relation to our 6 practice domains for these interventions). We also review reports from our Practice Leads and program leaders during this process;

(f) we aligned our workforce to support our model of care by updating all our position descriptions with expectations regarding the use of evidence-based psychosocial interventions, so as to ensure we attract staff who are interested in working within this framework. We also rebranded the professional senior roles as Practice Leads, invested in a Practice Development manager, recruited novel roles that support and promote the practice domains (for example, dual diagnosis clinicians, vocational consultant, exercise physiologist, and Eating Disorder Clinicians), and implemented support structures to build other clinicians' skills in relevant new areas.

MENTAL HEALTH SYSTEM AND REFORM

In your experience, how does the system we have now compare to what was envisaged in the 1990s?

What has been lost?

98 The following has been lost from our system compared to what was envisaged in the 1990s:

(a) the capacity to provide the appropriate duration of treatment has been lost;

(b) the vision for mainstreaming, which involves the transferring of the management and delivery of mental health services from psychiatric institutions to the general health sector, has not been realised. There appear, however, to be incremental shifts occurring at the Royal Melbourne Hospital, especially with the introduction of programs that bridge the ED and Inner West's Emergency Mental Health Team;

(c) the "outsourcing" of psychosocial services to MHCSS contributed to the loss of psychosocial emphasis and expertise, prominence of pharmacological model and the disengagement of consumers. The idea then was that public mental health services would provide clinical health services and MHCSS would provide psychosocial services. Fortunately, the tide is turning and NWMH is rebuilding the emphasis on psychosocial interventions – this will hopefully result in a greater range of approaches within public mental health services;

(d) the closure of drop-in centres operated by MHCSS, which were considered marginalising and contributing to social isolation.

What has been gained?

99 The following has been gained from our system compared to what was envisaged in the 1990s:

(a) there is much clearer evidence about what works and what does not in terms of treatment;

(b) there is a broader range of treatments and psychosocial interventions available;

(c) there is a much greater participation of consumers and carers in service leadership and workforce as well as in co-design philosophy. For example, there were a large number of consumers and carers in the group that informed the design of the new PARC for women, which would have facilities for women with young dependents (up to 3) and quiet spaces to separate those facilities from the other units;

(d) there are area-based, geographic catchment areas with a consistent range of services – this provides some predictability for consumers if they need to move between mental health services;

(e) the devolution of institutions provides much more independence for consumers, and allows greater focus by mental health services on more severe mental illness presentations.

What new trends have impacted on community needs since the 1990s?

100 There has been a loss of accommodation, due to the closures of supported residential services and rooming houses without new housing facilities.

101 The increase in disengaged consumers on treatment and/or forensic orders has created a small group of individuals with a high risk of threatening and assaulting staff, and are virtually "community untreatable". As recently as 3 years ago, we experienced a maximum of 3 to 4 "code greys" (that is, psychiatric behavioural emergency) within the clinic per year (for example, threatening behaviour, imminent threat to staff or co-

consumers or property damage), whereas this occurs 2 to 3 times per week now. It is clear that this is partly fuelled by increased use of ICE in the community, but this is contributed by the consumers' lack of hope, reduced engagement in recovery-oriented work, and the need for compulsory treatment for some consumers.

How has the system got to where it is now?

Are there ways in which you think the demand for services of the kind NWMH and Inner West provide is changing or will change significantly in the future? If so, what do you think the most significant changes are likely to be?

102 For Inner West, we expect significant population growth in the City of Melbourne, with high proportions of Culturally And Linguistically Diverse (CALD) consumers, students and younger people. There are annual increases in the homeless population in the CBD (as evidenced through the City of Melbourne's annual StreetCount program). Significant population growth (predicted to be about 80,000 people) is also expected at new developments at Fishermen's Bend.

103 The catchment areas of each of Mid West AMHS, Northern AMHS and North West AMHS also have growth corridors with different demographics.

What do you think are the most significant challenges facing the mental health system in meeting the needs of people affected by mental health?

104 The most significant challenges are:

(a) Model of care: Generally, as staff becoming more crisis-focussed, there is some loss of touch with the importance of long-term recovery work. As discussed above, there needs to be a shift in focus to include both pharmacological interventions and evidence-based psychosocial interventions;

(b) Staff well-being: There is increasing risk of exposure to occupational violence and a general lack of work satisfaction. Due to insufficient capacity to provide treatment for the appropriate duration and frequency for lasting recovery, staff are unable to see the impact of the work they are doing. This contributes to burnout and loss of staff. Inner West's AIU has one of the highest staff turnover rates in health services in Victoria;

(c) Workforce shortage: There are significant workforce shortages, with staffing gaps creating additional challenges for services. Nursing recruitment has required development of strategies such as international recruitment drives at least twice a year, with subsequent challenges of getting visas approved and obtaining registration with the Australian Health Practitioner Regulation Agency in time for work start dates.

What do you think are the critical elements of a well-functioning mental health system?

105 Critical elements of a well-functioning mental health system include the following:

(a) strong leadership and clear vision;

(b) adequate staffing and funding that reflects population growth and realistic CPI increases;

(c) funding to support infrastructure needs;

(d) cross-sector service development (for example, co-delivered services or blended teams with expertise in areas other than mental health, including community health, housing, AoD and social support services to improve consumer access to essential services);

(e) a commitment to co-designed services, with consumer and carer input at the leadership level;

(f) workforce availability;

(g) good supervision and support structures; and

(h) accounting for the unique needs within geographic areas.

What changes do you think would bring about lasting improvements to help people affected by mental illness, in relation to:

Access to treatment and services;

106 I think that changes which would bring about lasting improvements to help people access treatment and services include:

(a) significant investment to enable a larger proportion of people with severe mental illness to access and receive services for the appropriate duration and frequency;

(b) continued implementation of NWMH's model of holistic service provision through practice reform; and

(c) changes to the federal government's *Better Access* initiative to provide Medicare rebates for more than 10 sessions per calendar year for people with severe and enduring mental health conditions.

Navigating the mental health system;

107 I think that changes which would bring about lasting improvements to help people navigate the mental health system include:

(a) co-design of navigation resources by both mental health services and consumers;

(b) ensuring that consistent information about services is provided to the public through the websites of the Department and individual service providers;

(c) investment in the Department's webpage to provide user-friendly service information; and

(d) consumer and carer "concierge" roles at service sites.

Getting help to people when they first need it?

Drawing on your experience, how do you think the Royal Commission can make more than incremental change?

Embedding the model of care in the system

108 There is considerable talk in the industry about changing the structure of the system (for example, the catchment areas), but the most significant change that should occur is about what happens in the room between clinicians and consumers – that is, the types of services consumers and carers receive.

109 A system which holds public mental health services accountable for providing evidence-based treatments, including psychosocial interventions, is critical. It is of paramount importance that the Royal Commission identify ways to do this effectively. For example, funding should be activity-based and tied to clinical outputs. There should also be a real relationship between the Department as the funding body and the services for the accountability structure to be effective and to reduce the possibility of services working the system. Currently, there is only about one meeting per year between the Department and the services, and the Department does not appear to be aware of what's going on in the services. There should be investment in the Department's internal review team to allow them to better connect with services to review what is being provided.

110 Resourcing of community-based services for clinics and residential services should be significantly expanded to ensure services are provided to a larger proportion of the population, and to enable the realisation of NWMH's vision for holistic service delivery across the 6 core practice domains. In addition to increasing access to services, investment is also needed to enable evidence-based interventions are delivered according to the recommended frequency and for the appropriate duration according to each consumer's needs.

111 There should also be investment in the following to support the provision of holistic service delivery:

(a) co-delivered services or blended teams with expertise in areas other than mental health, including community health, housing, AoD and social support services to improve consumer access to essential services;

(b) alternative venues with extended hours that consumers can access 7 days a week instead of EDs (for example, the Safe Haven Café model);

(c) collaboration with consumer-led social firms (that is, businesses created to employ people who have a disability or are otherwise disadvantaged in the labour market) to create employment experiences for long-term unemployed consumers; and

(d) group and social programs to create opportunities for connection between consumers and to reduce isolation (for example, drop-in venues that are proximate to clinical services)

Funding Model

112 Equitable population based funding models should be utilised, incorporating complexity factors and taking into account the community resources and supports, as well as private mental health practitioners and GPs, that are available in the services' catchment areas.

Housing

113 Community residential services should be reformed and expanded to ensure that there is a continuum of housing across the spectrum, including CCUs (with expanded capacity), PARCs (with expanded capacity), AoD residential service and community mental health residential units. These housing facilities should have secure tenure and clinical outreach support, and should ideally be in small household groupings that allow social connection.

114 There should also be an expansion of crisis, transitional and permanent public housing that allow flexible provision of clinical outreach support.

sign here ►

print name Gail Bradley

date 26 June 2019

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GB-1

This is the attachment marked 'GB-1' referred to in the witness statement of Gail Bradley dated 26 June 2019.

Gail.Bradley@mh.org.au
1-North, Royal Melbourne Hospital
Grattan Street PARKVILLE

GAIL BRADLEY

SKILLS AND ABILITIES

Mental health service leadership

Service development and change management

Strategic partnerships

Budget management

Team building

Service evaluation, IT and data analysis skills

Highly developed writing skills

Consumer focus

Clinical psychology and professional standards

PROFESSIONAL EXPERIENCE

INTERIM OPERATIONS DIRECTOR
NorthWestern Mental Health (NWMH)
February 2019 – current

Operational responsibility for one of the largest publicly-funded providers of mental health services in Australia, providing a comprehensive, integrated range of specialist, community and hospital-based mental health services. Services are delivered for youth, adult and aged people who are experiencing, or are at risk of developing a serious mental illness in north-western Melbourne through six programs spanning 32 sites across the northern and western suburbs of Melbourne. NWMH is a clinical division of Melbourne Health with a budget of $350M and in excess of 1900 employees.

AREA MANAGER
Inner West Area Mental Health Service – RMH
November 2010 – February 2019, resume role July 2019

Manager of large metropolitan mental health service incorporating adult acute and specialist inpatient services (Eating Disorders, Neuropsychiatry), residential rehabilitation services and community mental health services (380 staff, $40M budget).

Key Achievements

- Major organisational change project "Adult Community Program Redesign" and practice reform
- Executive portfolios NWMH
    - Eating Disorders Regional Clinical Planning (2010)
    - Forensic Clinical Specialists coordination
    - Chair and Executive Sponsor - Safety and Inclusion Committee
    - Chair and Executive Sponsor – Improving services for Aboriginal and Torres Strait Islanders
    - NWMH Women's PARC development
    - NWMH PARC tender 2019
- Successful grant applications
    - Safety of Women in Mental Health Care (2011)
    - Breaking the cycle of homelessness (HOMHS) - $684K/yr

  - Pathways innovation fund for homelessness Melbourne City Council $150K (2018)
  - Prevention of violence in health services round 3 - $500K (2017)

Private Practice
Glencairn Consulting Suites
2009 – current
One clinical session of private practice per week for people with a range of mental health disorders. Clinical supervision to clinical psychologists and registrar program.

Performance assessor

Australian Health Practitioners Regulatory Board

2011 – current

Assess competency of psychologists following performance notification to Psychology Board of Australia. Conduct full day assessments in metro Melbourne, rural Victoria and interstate, train new assessors.

Operations Director (LSL cover)
NorthWestern Mental Health
Jan – March 2014

Clinical division of Melbourne Health, NWMH is a division of Melbourne Health with providing services to people with a serious mental illness through four Area Adult Mental Health Services, Aged Persons' Mental Health Program, and Orygen Youth Health.

- Product review and selection for roll out of community duress Safe-T-Card across programs
- Negotiation with DHHS and submission for MHaP Homeless program
- Reconstruction Executive Briefs database and development of dashboard in Excel
- Support to QPI in developing NWMH CE performance report

Senior Psychology Advisor (0.3)
NorthWestern Mental Health (2003 – 2010)
Psychology workforce planning, professional practice, service development issues and professional education for a workforce of over 100 psychologists within NorthWestern Mental Health Program.

Key achievements included:

- Established Senior Psychologists network and regular meeting
- Established annual Psychology Forum for psychologists employed within the service and engaged psychology academics in ongoing planning
- Conducted workforce analysis survey at regular intervals
- Primary author of strategic plan for the psychology workforce
- Developed business plan for private clinics within NWMHP to improve access to psychology and other discipline providers
- With NWMH Psychology Academic Advisor, established Placements Senior Psychologist/Entry Level Program position supporting a range of workforce initiatives including "Start your psychology career in NWMHP" brochure,

Psychology careers website on Melbourne Health internet, Psychology placements with NWMHP database established

- Developed network policies on Supervision, recruitment and professional standards requirements

Program Manager

Continuing Care Team (1995 -2010)

Inner West Area Mental Health Service – The RMH

A leadership role across 3 community mental health teams, supporting 5 team leaders and combined staff group of 58 multidisciplinary staff. Manager of the Continuing Care Team (1995), allocated Homeless Outreach Psychiatry Service (1999) and Primary Mental Health Team (2001).

Management of a multidisciplinary team of 30+ staff.

Key Achievements:

- Introduced a culture of evidence-based practice within the service
  - Needs for Service evidence-based treatment program planning
  - TRIP Relapse Prevention Program – all MDT staff trained and receive ongoing mentorship in interventions
  - Voices Clinic, metabolic monitoring program, vocational program, Impulse Tamers, Multiple Family Group Program
- Introduced Collaborative treatment planning CCT and HOPS (forerunner to NWMH Wellness and Recovery Plan)
- Manager/research collaborator Forensic Psychosocial Research Team – OH&S modifications, weapons policy, 75 community clinicians trained in use of HCR-20, established Impulse Tamers Violence Prevention program.
- AIMS – Assisted Intensive Medication Service – developed innovative evening outreach program using graduated levels of medication adherence support, behavioural cueing and self-management supports. Winner Victorian HealthCare Awards 2016
- Multiple Family Group Project - $150,000 Vic Health grant - randomised control trial to evaluate treatment outcomes for multiple family groups in English and Vietnamese. Published in peer reviewed journal (Psychiatric Services).
- Salvation Jane and Recreation Project - $30,000 Vic Health grant obtained to employ consumers to produce a networking newsletter and to establish recreation opportunities on weekends and after hours using a peer support model.

Homeless Outreach Psychiatry Service (1999 – 2010)

- Collaboration and co-authorship with Mark Hodge of service delivery principles for homeless people with mental illnesses "Frameworks for Homeless Outreach Psychiatry Services"
- Development of Psychological Assessment in a Homeless Setting (PATHS) program which provided psychological services to homeless people with high prevalence and personality disorders residing in Crisis Accommodation Support services.
- Elizabeth Street Common Ground Housing program for vulnerable long term homeless people – advocacy for clinical funding (secured $180,000), partnership development, in-service training for Elizabeth St staff

Primary Mental Health Team (2001-2010)

- Authored initial successful submission for PMHT to support GP's providing mental health support for people with high prevalence disorders. Team restructure 2008 to incorporate enhanced GP support functions for complex clients with personality disorders, dual diagnosis, short-term interventions for people with severe mental illness.
- Shared care service development
- Community agencies mental health consultation established – a monthly on-site consultation for Psychiatric Disability Rehabilitation and Support Services and accommodation support staff working with shared clients
- Waratah Monthly Education Series – established a program of lunchtime seminars for agencies in the Inner West catchment on topics identified by participants, delivered by IW staff

Acting Area Manager (Jan 2007 – Feb 2008)

Inner West Area Mental Health Service – The Royal Melbourne Hospital

Effectively managed complex organization incorporating adult acute and specialist inpatient services, rehabilitation unit and community mental health services (300 staff, $20 million budget).

Achievements include:

- Successful planning for conversion of sub-acute residential support service to a Prevention and Recovery Service with extended capacity for homeless
- Oversight of successful in-depth Australian Council of Healthcare Services (ACHS) review of IWAMHS-RMH
- Established highly functional alliance of PDRSS and clinical rehabilitation services with clear strategy to enhance collaboration via combined service forums, orientation

Acting Area Manager (Sep 1994 – Sep 1995)

South-West Area Mental Health Service

Managed inpatient and community programs within the South-West Sector, regular liaison with key stakeholders including regional management and Western Hospital regarding, oversaw development and recruitment to new CATT and MST services at South West AMHS, facilitated the development of linkages between the service network, participated in regional planning process for Werribee Mercy acute psychiatry service, management support to program leaders.

Coordinator (Oct 1993 – Sept 1994)

Saltwater Community Mental Health Service

Managed day-to-day operations of integrated service providing crisis assessment, continuing care and outreach services; developed appropriate budget and accounting processes; coordinated recruitment, ensured effective functioning of clinical teams (intake and case review). Implemented caseload management system.

Senior Clinical Psychologist (P-3) (Apr 1991 – Oct 1993)

Saltwater Community Mental Health Service

As senior psychologist, contributed a psychological perspective to the development and implementation of service policies and treatment approaches to a wide range of programmes. Developed assessment protocols, management plan and evaluation measures and procedures for Saltwater's Assertive Outreach Programme.

Clinical Psychologist (P-1) (Sept 1986 – March 1990)

Melville Clinic

Mixed case load of individuals with a wide range of emotional problems and disorders from diverse socio-economic and cultural backgrounds, liaison and consultation with community agencies, community education projects. Included eight month secondment to North West CATT.

Clinical Psychologist (P-2) (August 1985 – Sep 1986)

Vaucluse Hospital

The first psychologist employed at the hospital, developed psychological services for 14-bed psychiatric inpatient unit including psychological assessment, short-term individual and group therapy treatments; couple and family therapy, neuropsychological consultation to head injury unit.

QUALIFICATIONS

Bachelor of Behavioural Sciences (Hons), awarded La Trobe University Research scholarship
La Trobe University (1982)

Master of Psychology
La Trobe University(1985)

Graduate Diploma of Business – Organisation Change and Development
RMIT University (2000)

AWARDS

NWMH Excellence Award (2008)

Melbourne Health Celebrating Excellence nomination for the organisation's highest award "Melbourne Award" (2018)
https://www.thermh.org.au/file/4093

PUBLICATIONS & PRESENTATIONS

Bradley G, Couchman G, Perlesz A, Nguyen A, Singh B, Riess C (2006) Multiple-Family Group Treatment for English- and Vietnamese-Speaking Families Living With Schizophrenia. *Psychiatric Services*, 57: 521-530

Bradley, G and Foulds, M. (2013) "Public community mental health management of adult psychotic disorders: Evolving models and roles for psychologists", InPsych, Australian Psychological Society.

Paper entitled "Developing Effective Community Responses to Consumers with a History of Violent Offending" at the Working within the forensic paradigm conference, Prato, Italy, September 2011.

Paper presentation "Transforming mental health services for delivery of evidence-based psychosocial treatments: what works in supporting practice change" *Gail Bradley M.Psych*. ("Making Real Change Happen" ISPS conference, Liverpool, United Kingdom, September 2017).

Paper presentation "Strengthening and developing communication between consumers, families and services". Alice Berliner, MSW| Alison Lewis MFT |Gail Bradley M.Psych. ("Relationship and experience in psychosis" ISP conference New York 2015.)

Safer Care Victoria presentation February 2018 "Transforming mental health services for delivery of evidence-based psychosocial treatments"

Workforce innovation day DHHS 2017 "Transforming mental health services for delivery of evidence-based psychosocial treatments"

Gleeson J, Nathan P, Bradley G (2006) The need for the development and evaluation of preventive psychosocial forensic interventions in mainstream adult community mental health services. *Australasian Psychiatry* 14 (2), 180–185

Holmes A, Hodge M Lenten S, Fielding J, Castle D, Velakoulis D, Bradley, G (2006) Chronic mental illness and community treatment resistance. *Australasian Psychiatry*, 14(3):272-276

Holmes A, Hodge M, Newton R, Bradley G, Bluhm A, Hodges J, Didio L, Doidge G (2005) Development of an inner urban homeless mental health service. *Australasian Psychiatry* 13 (1), 64–67

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GB-2

This is the attachment marked 'GB-2' referred to in the witness statement of Gail Bradley dated 26 June 2019.

adult
community
service

Practice Guide

A Recovery approach to our Adult Community Services August 2013

Renee Sutton, No title, 1959, gouache on paper, 33.5x42cm. This work is from the Cunningham Dax Collection, which is part of The Dax Centre. For more information about this artwork please see page 3.

NorthWestern Mental Health

Disclaimer

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Acknowledgements

This guide has been developed and endorsed by members of the NWMH Adult Community Program Redesign (ACPR) Content working group.

The following people have made specific written contributions to this document:

Wanda Bennetts	Project Consumer Consultant, ACPR, NWMH and Northern AMHS and Inner West AMHS
Gail Bradley	Area Manager, Inner West AMHS
Jenny Burger	Project Carer Consultant, ACPR, NWMH
Associate Professor Peter Burnett	Acting Executive Director, NWMH
Elizabeth Currie	Service Improvement Officer, NWMH
Gary Ennis	Senior Psychiatric Nurse (Education & Workforce), NWMH
Peter Kelly	Director of Operations, NWMH
Dr. John Farhall	Consultant Clinical Psychologist and Senior Lecturer, Northern AMHS
Dr. Sabin Fernbacher	Women's Mental Health Consultant/ FaPMI Co-ordinator/ Project Manager Aboriginal Health, Northern AMHS
Margaret Foulds	Senior Clinical Psychology Advisor, NWMHS
Dr. Shona Francey	EPPIC Stream Leader and Senior Psychologist, Orygen Youth Health
Associate Professor Carol Harvey	Director Psychosocial Research Centre (Department of Psychiatry, University of Melbourne) and Consultant Psychiatrist, North West AMHS
Anne Hastie	ACPR Project Manager, NWMH
Lisa Hebel	Senior Social Work Advisor, NWMHS
Penny Herbert	Quality, Planning & Innovation Manager, NWMH
Dr. Alex Holmes	Consultant Psychiatrist, Inner West AMHS
Brian Jackson	Senior Nurse Advisor, NWMH
Dr. Simon Jones	Consultant Psychiatrist, Inner West AMHS
Dr. Vinay Lakra	Acting Director of Clinical Governance, NWMH & Director Clinical Services, North West AMHS
Kate Lhuede	Senior Occupational Therapy Advisor, NWMHS
Belinda McCullough	Service Development Manager, NWMH
Annette Mercuri	Carer Consultant, Northern AMHS
Greg Miller	Education and Workforce Development Manager, NWMH
NWMH	Consumer and Carer Advisor Group Members
Angela Obradovic	Chief Social Worker/Family Work Development Co-ordinator, Northern AMHS
Martin Pradel	Senior Clinician, Victorian Centre of Excellence in Eating Disorders
Allan Pinches	Consumer Peer Support Development Worker/Consumer Consultant, Northern AMHS
Lily Rodriguez	Senior Nurse, MCCT, North West AMHS
Lucy Smith	ACPR Project Manager, NWMH
Dr. Lisa Soares	Service Improvement Coordinator, NWMH
Associate Professor Suresh Sundram	Director of Clinical Services, Northern AMHS, Director Northern Psychiatric Research Centre
Shane Sweeney	Manager of SUMITT, NWMH
Suzanne Turner	Service Development Coordinator, NWMH
Associate Professor Ruth Vine	Director of Clinical Services, Inner West AMHS
Lindsay Vernon	Chief Occupational Therapist, North West AMHS

We would also like to acknowledge all the NWMH staff that contributed directly or indirectly to the development of the Practice Guide.

Acknowledgement of the artwork:

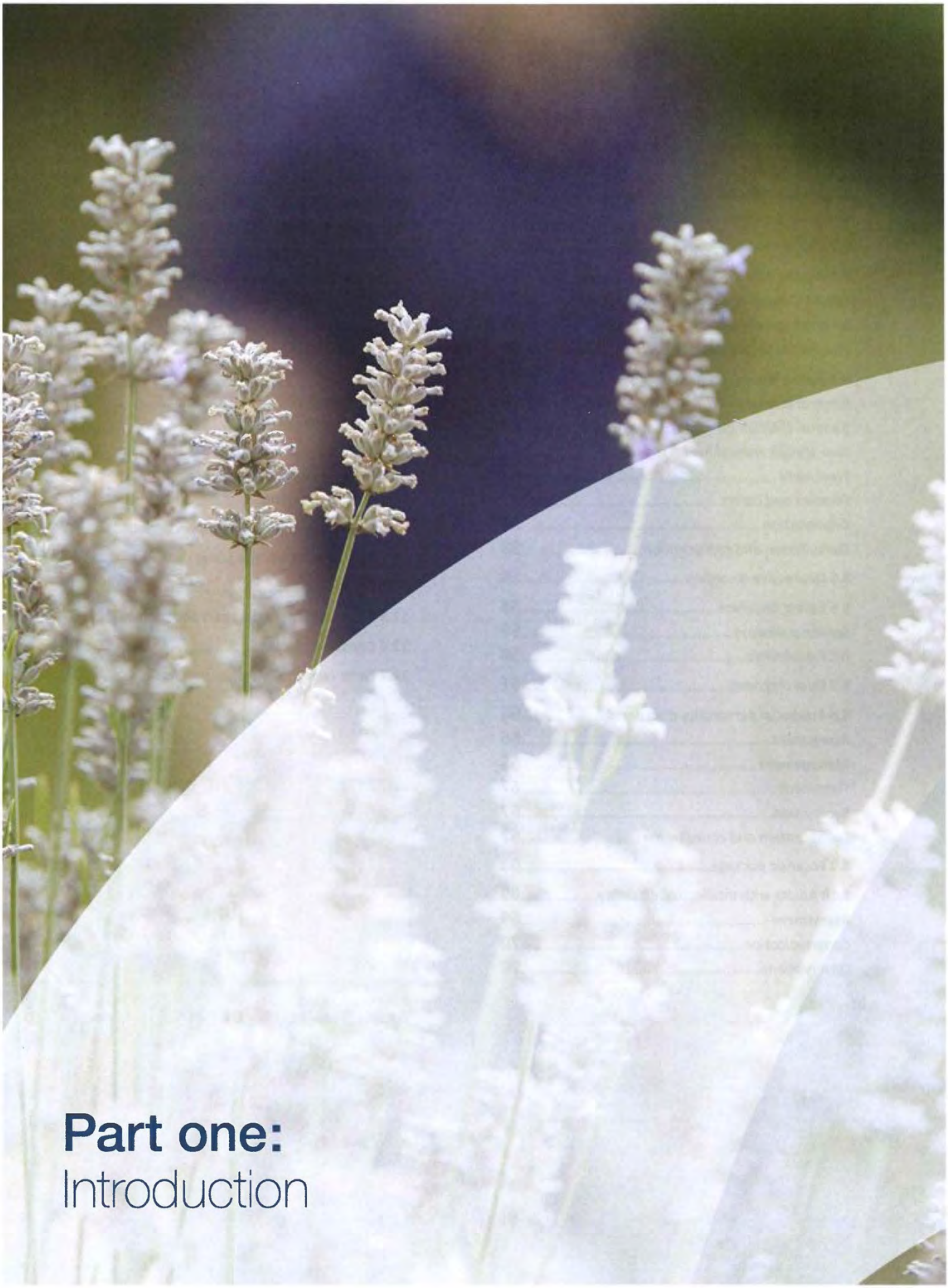
Despite no formal training, Renee Sutton has been making art for over 50 years. It was at Larundel Psychiatric Hospital in the occupational therapy programs devised by Dr Cunningham Dax, that Sutton began to paint on a regular basis. Sutton's works reveal scenes from her childhood; representations of concerts and exhibitions she had attended as well as expressions of her innermost thoughts. As Sutton explains:

"It has not only been therapy, but it's helped me to solve and realise problems and things I didn't realise when I was younger."

The Cunningham Dax Collection, which is part of The Dax Centre, consists of over 15,000 artworks including works on paper, photography, paintings, sculptural work, journals, mixed media and video created by people with an experience of mental illness and/or psychological trauma.

The Dax Centre and to view our online gallery of past exhibitions, visit: http://www.daxcentre.org

Contents



Part one:
Introduction

Part one: Introduction

1. Background and purpose

The Adult Community Program Redesign (ACPR) aims to improve the clinical outcomes and the experiences of individuals and their families/carers by redesigning the specialist care, treatment and support provided by NWMH in community settings. To meet this aim, we have pursued three objectives:

1. To provide **consistent evidence-based care** to our consumers and their family/carers across NWMH
2. To provide **seamless, appropriate and acceptable services** to our consumers and their family/carers
3. To **make the best use of available financial and human resources**, including the expertise, skill and experience of our staff and those of other clinical and non-clinical service providers, to meet the challenges of increasing service demand.

The *Framework for Care* recommended that interventions and treatments be supported by a 'clinical interventions guide' or a Practice Guide, providing clear information and expectations for clinicians, individuals and family/carers about recommendations for each area of need or difficulty (*section 3*). This Practice Guide ('the Guide') orients NWMH clinical staff to the new emphases of our clinical practice, focusing on the delivery of evidence-informed care. It addresses how we may better integrate the Recovery Framework, which has been adopted as our broad approach to care, and how to choose priority treatments and programs. It includes guidance on how decision-making about treatments and services for each individual can proceed, given the often complex factors that must be balanced.

The Guide collates recommendations from sources including State and Commonwealth governments, internationally-recognised recovery resources, clinical practice guidelines, and from local innovation and expertise within NWMH. It must be recognized, however, that many clinical practice guidelines were not written with a recovery framework in mind, and are not always congruent with the principles in this Guide.

The Guide is based on the principles of evidenced-based and evidence-informed care and the concept of personal responsibility. It supports wellness planning and collaborative transition between service systems. Like all guides, it is not definitive in prescribing a particular course of action but instead is a resource to help clinicians work with individuals in choosing from a range of options.

"This Practice Guide is not complete, further sections will be added and existing sections regularly updated and improved. It is intended to be an evolving document, and we welcome suggestions which should be discussed locally and then forwarded to Belinda McCullough."

The following definitions are important to understanding the Guide (other definitions are located in the Glossary):

- **Consumer/ individual/ person**. People receiving care are referred to as individuals and/or persons. The term 'consumer' is used when referring to the broader system or organisation (for example, 'consumer peer support worker').
- **Family/Carer**. NWMH uses this term to acknowledge the range of adult and child family members or significant others of the person receiving care, including those who may or may not identify as 'carers' of their family member with a mental illness.
- **Family**. The biological or chosen family as defined by the consumer, for example spouse/partner, dependent and adult children, parents, siblings or grandparents.
- **Carer**: A person who actively provides support or care for a person with a mental illness with whom they have an ongoing relationship, even if they do not live with them. A carer can be a family member, friend or other person, including a child or young person (other than an employed carer) who has a significant role in the life of the person with mental illness. The role of carer is not necessarily static or permanent, but may vary over time according to the needs of the both the consumer and carer. A carer is not necessarily the next of kin

2. Working towards a recovery approach

Australian mental health services have adopted recovery frameworks as their overarching context for service delivery. Both the Victorian Framework for Recovery-Oriented Practice and draft National Recovery-Oriented Mental Health Practice Framework have been embraced as the focus of our Adult Community Services. The recovery frameworks support our delivery of care and complement existing professional standards and competency frameworks. We also acknowledge the work of Mike Slade (2009) on personal recovery and clinical recovery as an important influence.

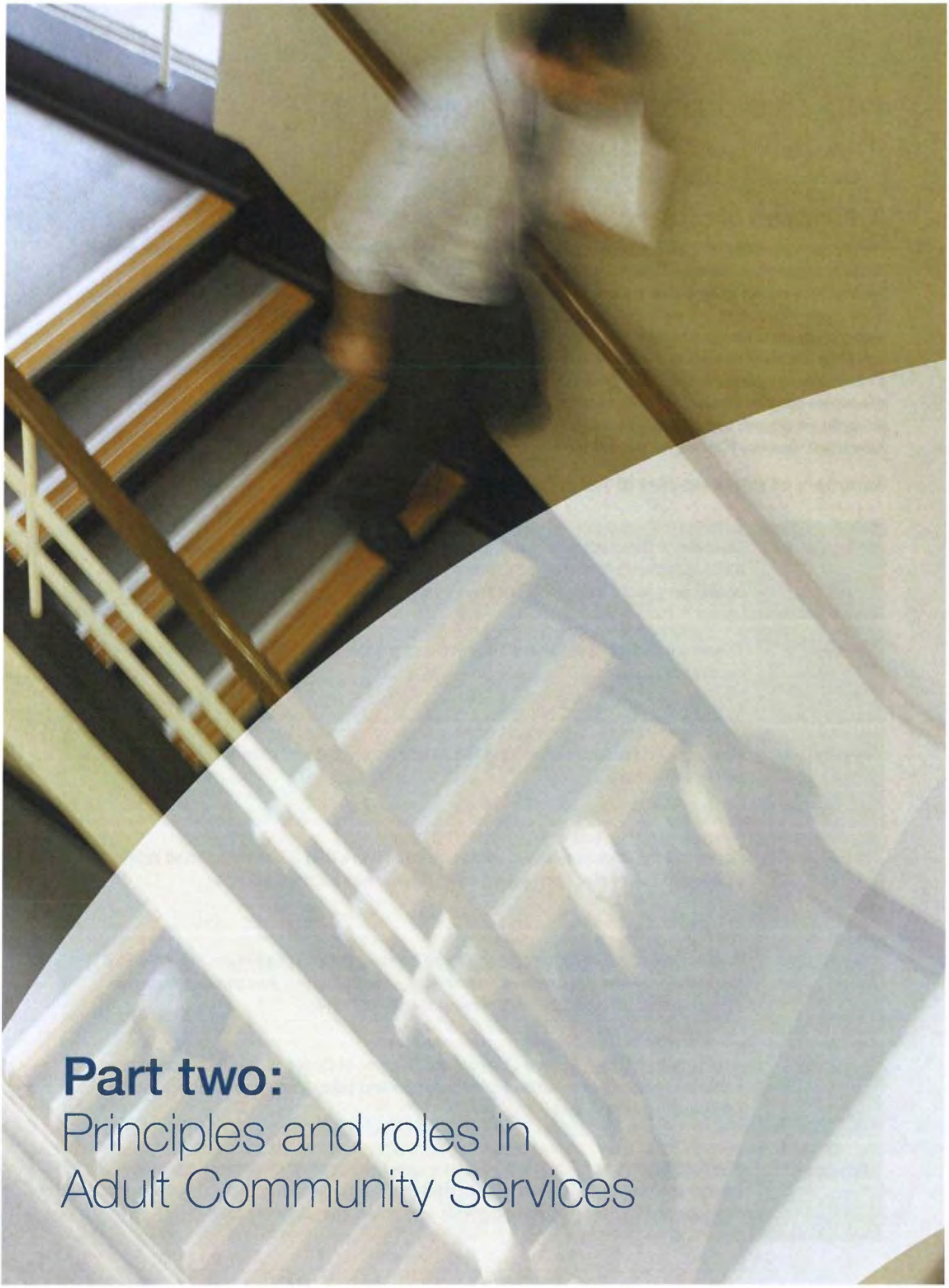
Personal recovery is the process through which individuals turn their lives around so as to live a satisfying, hopeful and contributing life (Slade, 2009). Our services need to identify, enable and support the individual's recovery efforts, being careful to not inhibit the person's own efforts to sort out their life. Personal recovery is focused on the individual but is also extended to include families and carers, consistent with the draft National Recovery-Oriented Framework.

In our Adult Community services, we would expect our major contributions to personal recovery will commonly involve the following principles:

1. The clinician's role is to act as a guide and support the individual and the family/carers. This involves working alongside consumers on their goals and actively resourcing recovery tasks such as developing a positive identity, incorporating the illness, allowing the person opportunities to self-manage, giving as much power and choice as possible, and assisting the person to develop valued roles within their community.
2. Facilitating clinical recovery through reducing problematic symptoms, addressing vulnerabilities that put the person at risk for future illness episodes, and enabling restoration of social functioning.
3. Organising our service structures, resources and operational processes to enable the individual's personal recovery.

Our community teams will promote the wellbeing of individuals within each of nine domains described in the Victorian Framework for Recovery-Oriented Practice, throughout the continuum of care. We have translated the nine domains into thirteen practical principles applicable to be delivered across our three core pathways of care (brief intervention, ongoing intervention and consultative response).

The recovery framework also identifies the key capabilities of the mental health clinician, good practices, and the need for leadership within a recovery-orientated system. For example the core principle of 'Promoting autonomy and self-determination' advocates for the individual's own decision-making in all areas of life, but when a person is unable to self-advocate then services should ensure that the person's views are properly represented (2011, p.9). Mental health services recognise the individual's lived experience and expertise and encourage informed risk-taking (the 'dignity' of positive risk-taking), working to optimise informed choices and consumer-led decisions within a safe and supportive environment. This is achieved through the key capabilities of the clinician, their behaviours, attitudes, skills and knowledge. The clinician, as a 'recovery guide', can provide the necessary information to support the person in making decisions about their mental health care, is committed to involving the person and their families/carers in all aspects of service delivery, and has the knowledge of relevant legislation and policies on consumer rights and consumer and carer participation (2011, p.9).



Part two: Principles and roles in Adult Community Services

Part two: Principles and roles in Adult Community Services

3. Principles of care

The principles described here will clarify practice methods and priorities within our new Adult Community Services. They are not an exhaustive guide to practice, as many sound principles of care are already understood and routinely implemented in NWMH. The improvements reflect the themes of community redesign: implementing a more recovery-oriented service, and extending the use of evidence-based and evidence-informed practice. The principles are grouped by four phases of care: Assessment, Recovery Planning, Review, and Transition.

The principles reflect the heart of our practice changes. Clinicians and community teams should know, understand and refer to these principles as they provide the best available recovery-oriented clinical treatment and care.

Summary of the principles of Assessment

Principle 1	The role of clinicians within a recovery framework encompasses assessment and implementation of clinical interventions, as well as being a 'guide' to consumers and a 'resource' for their evolving recovery.
Principle 2	The way in which assessment and recovery planning are conducted supports recovery.
Principle 3	Assessment is orientated around the needs, strengths and challenges identified by the individual.
Principle 4	Assessment is conceptualised as one piece of work that is developed and refined as needed over time. Each assessment activity has a stated purpose.
Principle 5	Assessment is oriented around the needs, strengths and challenges identified by the individual, the perspective and needs of family/carers, and the contributions of mental health clinicians and other providers of care.
Principle 6	Assessment for people on a Community Treatment Order or those reluctant to consider treatment maximises collaboration and takes into account the added complexity of these factors.
Principle 7	The formulation considers the person's views about their challenges, strengths and needs; the views of involved others; and the clinician's assessment. The formulation explains and expands on the diagnosis and drives the recovery plan.

Summary of the principles of Recovery Planning

Principle 8	The recovery plan belongs to the person. The clinician's role is to support relevant parts of the plan, along with the support of other individuals/services.
Principle 9	Recovery Plans focus on realistic and effective actions for a small number of priority needs. Actions may include clinical treatments, other interventions to support personal recovery, and the engagement of people and agencies.
Principle 10	The process of developing recovery plans involves collaborative decision making with all parties, and thoughtful decisions based on evidence from: the person; their family/carer; the clinical team; and, research, about potentially helpful treatments.
Principle 11	Individuals who are at risk for continuing symptoms of a disorder or for future episodes are invited to develop a Wellness Plan.

Summary of the principles of Review and Transition

Principle 12	Reviews consider the effectiveness of interventions at each review point and justify changes as needed. Reviews may be routine or be requested by any person involved in the care of the individual.
Principle 13	Transition plans are discussed between all parties throughout the person's episode of care and Advance Statements and Wellness planning incorporated when appropriate.

General principles to guide assessment and recovery planning

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
1.	The role of clinicians within a recovery framework encompasses assessment and implementation of clinical interventions, as well being a 'guide' to consumers and a 'resource' for their evolving recovery.	A clinical mental health service integrates its professional assistance within the broader perspective of a personal recovery framework. The process of recovery involves an internal change in how the person sees themselves in the world. Clinicians cannot directly *make* recovery happen. We can conceptualise our role as a 'guide' or as a 'partner' who can offer a wide range of 'resources'. The clinical services we offer can be a particularly helpful 'resource' in helping individuals move on in life	*Being a 'guide' or 'resource' may include:* ▪ understanding the person's view about what recovery means to them ▪ being prepared to 'sit' with the person and, as the person is ready provide the opportunities for choice ▪ being a responsive contributor to the individual and the family/carer ▪ encouraging capacity for personal responsibility ▪ assisting the person to nurture a positive view of themselves ▪ supporting access to activities that support personal growth and interpersonal and community connection ▪ supporting people to have access to and/or engage with spiritual and cultural experiences that are meaningful to them *As well as offering clinical professional treatments and services*
2.	The way in which assessment and recovery planning are conducted supports recovery.	Assessment and recovery planning is a dynamic, ongoing process. Consumers have strongly advocated that the messages of hope and self-determination that are central to recovery can be and should be implemented, not only in the interventions provided but also the way our services are experienced by consumers and others involved in their care. As well as reflecting both human rights and our organisational values, conducting our work in this way is also a valuable opportunity for modelling hope, respecting different sources of expertise and supporting the consumer to further develop autonomy.	*The processes of assessment and recovery planning support recovery principles by:* ▪ fostering early and safe engagement and ensuring the consumer and their families feel heard and understood ▪ using language that is meaningful and strengths-based ▪ promoting a context of hope ▪ attempting to meet individual needs by being sensitive to values, beliefs and preferences regarding their treatment ▪ fostering culturally-sensitive autonomy and self-determination ▪ supporting positive identity, social roles and participation and fostering meaningful familial and social connectedness ▪ respecting preferences whilst working collaboratively with consumers and their families when making decisions about care ▪ actively negotiating information-sharing across the treatment partnership, covering confidentiality and the needs of families/carers for essential information ▪ working collaboratively within teams to minimise duplication and maximise a positive experience for those involved in the person's care.

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
3.	Assessment is oriented around the needs, strengths and challenges identified by the individual.	Mental health clinicians have traditionally focused on understanding 'where individuals are' in the course of a disorder, and its implications for interventions. A recovery framework focuses attention on 'where individuals are' in their pathway of personal response to, and recovery from, the impact of the disorder. Both are critical to informing how best we can help.	*The clinician:* ▪ identifies needs from the individual's perspective ▪ assesses the 'phase' or 'stage' of recovery (for example, early – overwhelmed by consequences of the disorder; middle - some self-management and emerging life directions) ▪ assesses the need and/or difficulty ▪ identifies the individual's strengths and qualities that can contribute to personal recovery ▪ identifies the strengths and qualities of the family/carer and social environment that can contribute to recovery ▪ understands the individual's story and ensures that all perspectives are heard and respected ▪ supports the development of a positive sense of self and identity.
4.	Assessment is conceptualised as one piece of work that is developed and refined as needed over time. Each assessment activity has a stated purpose.	Depending on the purpose of the assessment, its scope may be broad or narrow. Articulating the purpose helps to decide what needs to be included and what does not, and at what level of detail. Conceptualising assessment as one piece of work that is refined over time may help to: ▪ avoid unnecessary duplication of assessment and recording ▪ ensure information is complete and both historically and currently accurate. The assessment is documented as a record of the content, which is added to over time.	*Some examples of the purpose of an assessment are:* ▪ 'To understand a recent exacerbation of symptoms and formulate a plan of action' ▪ 'To determine whether a mental health problem that falls within the scope of our service charter is present' ▪ 'To inform the planning of supports and services that will facilitate further recovery over the next 6 months' ▪ 'To understand the impact of the illness on family/carer relationships and explore options to meet the needs of the family as a whole' *It is recommended that:* ▪ Subsequent assessments should be recorded through completion of the 'dynamic' component of the In Depth Assessment and this should build on the information initially collected. ▪ Clinicians should add new or updated material to the static components of the In Depth Assessment only as they change, aiding integration of information collected over time. ▪ All significant assessment information should be located as a unit in one part of the clinical record (or retrieved as a unit), to promote ease of access ▪ New additions to the assessment should be identified, signed and dated. *Examples of static/updatable sections of an assessment include:* ▪ past psychiatric history ▪ family history and structure ▪ developmental history ▪ employment history ▪ strengths ▪ early warning signs and relapse patterns

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
5.	Assessment is oriented around the needs, strengths and challenges identified by the individual, the perspective and needs of family/carers, and the contributions of mental health clinicians and other providers of care.	Purposeful mental health service provision is assisted by clarifying and agreeing about the difficulties to be understood and/or the needs (goals) to be addressed. This can be aided by determining, and discussing, similarities and differences in view about strengths and challenges between the main parties involved.	*The clinician can:* ▪ help direct the depth of assessment required in different domains ▪ identify the individual's perspective, including their views about their needs and difficulties, identified strengths, values and resources, their treatment preferences, and the needs of their family including dependent children ▪ identify the family/carer perspective, both about the individual's situation, including the treatment and support needs of the consumer and their own relational/caring needs, including those of dependent children ▪ identify the perspectives of mental health clinicians and other key individuals/support people with knowledge of the individual and their families/carers ▪ help focus the process of formulating how the difficulties have occurred.
6.	Assessment for people on a Community Treatment Order, or those reluctant to consider treatment, maximises collaboration and takes into account the added complexity of these factors.	Involuntary/compulsory status limits self-determination and decision-making. Reduced or absent collaboration makes assessment and information-gathering more complex. It can disempower the individual from actively contributing to the decision-making process. A focus on strengths and the efforts of the person is recommended.	*Implications for the* ***process*** *of assessment and recovery planning:* Collaboration is not an all-or-none process. Best practice in relation to Community Treatment Orders (CTOs) and involuntary admissions recognises any power differences between those involved. It seeks opportunities to provide individuals with choice and the ability to exercise autonomy within any constraints. Specific activities include: ▪ creating a partnership relationship which amplifies the individual's effort towards recovery ▪ a focus on amplifying strengths as well as identifying difficulties ▪ ensuring individuals are aware of their legal status and rights ▪ involvement of others, particularly family/carers ▪ consideration of involving consumer and/or carer peer support workers ▪ conducting interviews and discussions with procedural fairness including an informative explanation of the process, sympathetic acknowledgement of the individual's perspective, and a calm manner ▪ maximising individual choice and minimising coercion within any constraints of the involuntary status and risk ▪ building trust and collaboration in order to minimise the period of coercive care ▪ documentation of the assessment, as a reflection of the process *Implications for the* ***content*** *of assessment and recovery planning:* ▪ Additional time or effort may be required to complete assessment and recovery planning. ▪ Negotiating the involvement of other parties in assessment and treatment planning may require time and sensitivity.

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
7.	The formulation considers the person's views about their challenges, strengths and needs; the views of involved others; and the clinician's assessment. The formulation explains and expands on the diagnosis and drives the recovery plan.	Formulations in our redesigned service system will integrate clinical and recovery factors relevant to the person's identified needs or difficulties, in order to better understand the individual's lived experience. In this way, their purpose includes, but extends beyond, a justification of diagnosis. A diagnosis and differential diagnosis prompt consideration of the likely course of disorder and potential treatments. Early consideration of the diagnosis promotes earlier access to the specialist treatments and interventions that may be required, which in turn supports better outcomes.	*A formulation includes:* ▪ how the identified needs and difficulties appear to have arisen, including precipitating factors, ongoing vulnerabilities and any continuing disorder ▪ factors that appear to be exacerbating or perpetuating these needs and difficulties ▪ personal strengths of the individual that may be protective and drawn upon to address these needs and difficulties. ▪ aspects of the person's interpersonal, social and physical environment that are detracting from or supporting resolution of these needs or difficulties. *As a clinician:* Holding a view about the provisional diagnosis or pre-existing diagnosis prompts consideration of the need for specialist interventions at an early stage in the person's care. Practical activities that will support this include: ▪ early access to medical input, either at the initial assessment or in the following days ▪ at the point of local area intake, identifying a pre-existing diagnosis may help identify the appropriate clinical expertise, for example the inclusion of forensic specialists, dual diagnosis expertise, eating disorders specialist, or other medical involvement at the assessment ▪ processes which support prompt clinical decision making and timely clinical review will also assist.

General principles to guide recovery planning and implementation

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
8.	The recovery plan belongs to the person. The clinician's role is to support relevant parts of the plan, along with the support of other individuals/services.	What the individual's recovery 'looks like' is defined by them and 'belongs' to them – everyone's view on their personal recovery will 'look different'. Our role as a service and as clinicians will support each person's recovery.	*Understanding the extent and limits of our role will be supported by:* ▪ developing a clear understanding with each person about what 'recovery' means and would look like/feel like to them, recognising that this may evolve over time. ▪ working jointly on a plan to achieve these goals, to identify which actions/activities the clinician is supporting, those that other services might support, and those that the person/family/friends are supporting.
9.	Recovery plans focus on realistic and effective actions for a small number of priority needs. Actions may include clinical treatments, other interventions to support personal recovery, and the engagement of people and agencies.	NWMH encourages an integrated approach to treatment and supporting recovery, in which clinical treatment and other actions are planned and implemented in concert. *Please note:* **1.** Collaborative partnerships include providers external to NWMH. The NWMH recovery plan might guide the role of all agencies or, alternatively, be confined to the activities implemented by NWMH as part of a wider plan managed by another agency. **2.** Some recovery actions will be personal to the consumer (for example seeking out former friends, learning meditation). Some people may wish these actions to remain private, and others may choose to share and record these.	*Recovery plans for the current episode include:* ▪ a statement of each priority need or difficulty ▪ any proposed action for each priority need or difficulty ▪ a rationale for priority actions or for the absence of action at this time ▪ a statement of expected short and long term outcomes ▪ a time frame for review ▪ a note about the response of the individual and other people to the plan, including agreed elements and different views ▪ documentation of the respective roles and responsibilities of our services and external parties involved in developing the plan (for example private providers, community-managed MH services), including clarification of lead provider status ▪ providing episode-oriented services and treatments that are consistent with, or which actively contribute to, minimising future problems, for example emergency admission for a person with borderline personality disorder may trigger the development of a Wellness Plan for consumer-initiated preventive admission in the future. *The actions and rationale for the recovery plan arise from consideration of:* ▪ the phase of any disorder present and the stage of personal recovery (for example overwhelmed vs emerging life directions vs significant self-management) ▪ recommended clinical treatments and interventions ▪ actions that may foster or strengthen self-management over time ▪ how consumer strengths will be utilised and extended ▪ how the current actions can also contribute to recovery in the longer term, when an ongoing vulnerability or ongoing disorder is identified.

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
10.	The process of developing recovery plans involves collaborative decision making with all parties and thoughtful decisions based on evidence from the person, their family/carer and the clinical team, and research about potentially helpful treatments.	A principled and clearly communicated process for decision-making is central to building and maintaining collaborative engagement with all parties, even in the face of involuntary status or disagreements about aspects of the services offered. For the individual, building an understanding, based on personal experience, of what helps is fundamental to long term self-management and recovery. This process can be explicitly fostered by mental health services. Both individuals and their families/carers can bring valuable personal experience.	*Decision making about services and treatments should:* ▪ address a small number of priority needs identified during assessment and be consistent with the formulation ▪ take into account the likely benefit over time and not just this episode of care ▪ take into account views that (where possible) have been shared by all people involved ▪ make the greatest contribution to meeting the priority needs ▪ include a rationale for decisions made, including pros and cons of alternatives considered ▪ document what may be required to better meet the wishes/needs of the individual or their family/carers/others where there are disagreements ▪ reflect recommendations regarding evidence-based and evidence-informed care, accounting for: – whether an evidence-based treatment guideline for this problem is available – recommendations of the relevant clinical practice guideline – what evidence-informed interventions are available for this problem – individual characteristics, circumstances and culture of the individual – individual and family/carer preferences, social and cultural context – lived experience and peer knowledge – available expertise and resources (including consumer support networks), and organisational policies and constraints. *Personal evidence' is sought and used to inform recovery plans by:* ▪ encouraging individuals to reflect on and refine their personal understanding of what helps ▪ encouraging the individual, family/carers and service providers to share their perspectives on what helps and hinders recovery ▪ capturing key learnings from this personal evidence in the recovery plan.
11.	Individuals who are at risk for continuing symptoms of a disorder or for future episodes are invited to develop a Wellness Plan.	Wellness plans can support many individuals to better understand and take greater control of their illness management and recovery. Their effectiveness is enhanced when they are collaboratively developed in consultation with close others and ongoing support organisations.	*Activities to consider include:* ▪ joint meetings with the consumer, family/carer, other services to identify difficulties, strengths and needs during times of symptom return ▪ documenting these views and plans in the Wellness Plan provided to all people. *Note that there is some evidence that the balance of attention is best weighted to positive wellness actions rather than excessive vigilance about symptom re-emergence.*

General principles to guide review and transition

No.	Principle	Rationale – Why?	Recommended process, practical activities and examples
12.	Reviews consider the effectiveness of interventions at each review point and justify changes as needed. Reviews may be routine or be requested by any person involved in the care of the individual.	An evidence-based approach to treatment includes learning from the experience of implementing a treatment. Seeking evidence (from consumer, family/carer, tests, etc) about the effectiveness of current treatment elements can inform a thoughtful appraisal of how best to proceed. This helps build a picture over time of what has been tried, and what has helped and not helped. Individuals, families/carers, clinicians and partner agencies should feel free to initiate a discussion of progress with, and possible changes to, a recovery plan. The purpose of a focused re-assessment is to identify factors that have contributed to the change in functioning: this may also require update to the formulation or a re- formulation.	*Reviews should:* ▪ include thoughtful consideration at each time point ▪ be collaborative and inclusive ▪ explore any implications for changes to the plan ▪ note a rationale for changes to a recovery plan, referring to any observed and reported effectiveness of previous actions and to any changed circumstances, including changes in external providers or supports ▪ consider progress by, adequacy of, and changes in the external environment (for example, supports, involved providers) ▪ take into consideration changes in circumstances or level of functioning.
13.	Transition plans are discussed between all parties throughout the person's episode of care and Advance Statements and Wellness Planning incorporated when appropriate.	The current episode of care for many consumers is brief, relative to the time in which the service is not involved. A critical aspect of our role is to establish the conditions for the consumer to function well after transition. This issue should be considered early in the episode of care. A Transition Plan that includes other providers and family/carers enables them and the consumer to make the most of what has been learned in the current episode of care. Where development of Wellness Plans or Advance Statements is agreed as a part of the Recovery plan, they should be considered an essential element of service provision to be completed within the episode of care.	*Information to be discussed with the next provider of care includes:* ▪ the priority needs which the episode of care has sought to address ▪ advance statements and wellness plan (relapse management) ▪ recovery needs that can be supported in the period ahead ▪ risk issues ▪ formulation ▪ details of ongoing treatment and any suggested future treatment. The primary carer may not be the same person as the next of kin. Transition documentation should make clear who is the 'primary carer' (i.e. the family member or other person most involved in the consumer's care) and (with permission) state their full name and contact details, as well as noting other involved family members and next of kin (if different).

4. Framework for Care

The Framework for Care reflects the intention to conserve and promote the strengths of the existing adult mental health services while constructively addressing the challenges arising from current structures and processes. In the previous four-team structure, CATT, MSTS, CCT and PMHT had discrete functions and operated relatively independently. They have been replaced by integrated multidisciplinary teams across Area Mental Health Services, enabling NWMH to deliver highly responsive, person-centred specialist mental health care across the catchment. Each Community team will be responsible for delivering the same wide range of responses to meet individual and family/carer needs and preferences.

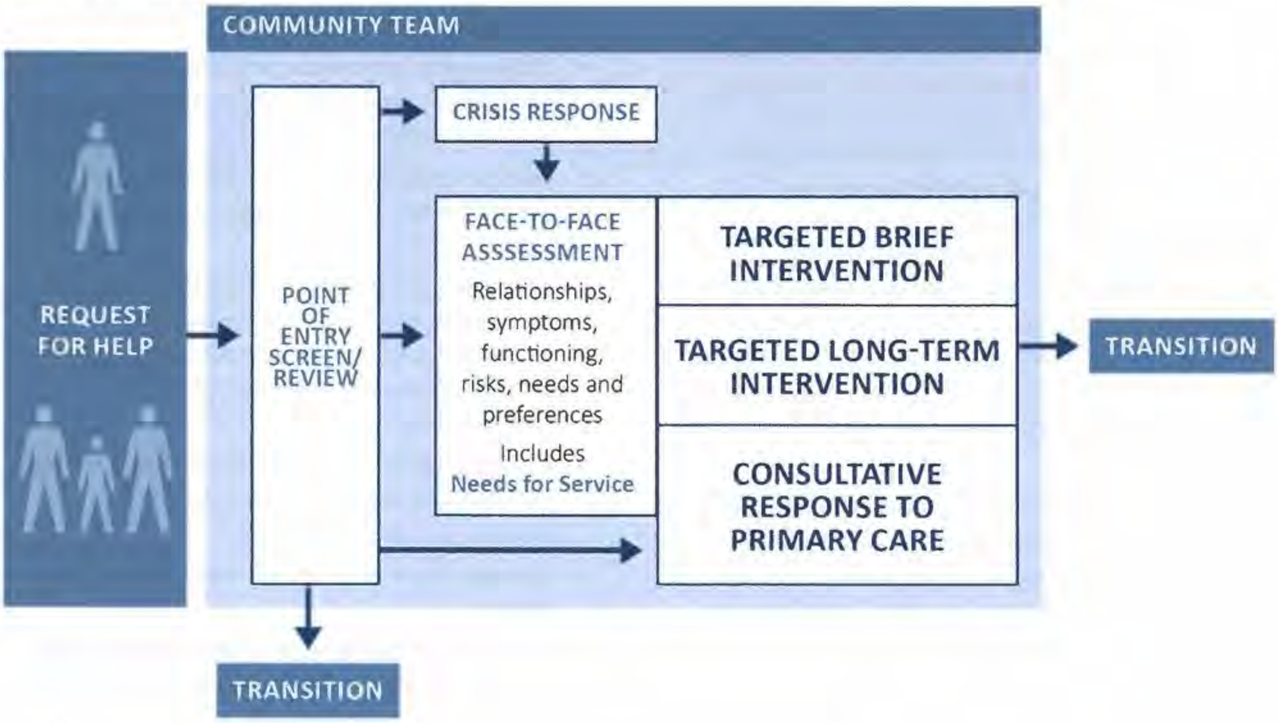
The number of Community teams in each AMHS is based upon demographics, geography and need. The teams, structured similarly across each area, will each provide a suite of evidence-based interventions, treatments and approaches to care. Workforce arrangements, including staffing structures and workforce supports such as training and supervision, will be implemented to support the delivery of care in the community (see Section 9.2).

The aim of the adult community teams is to provide:

- **Easy access** to assessment, with fewer overall assessments, and a philosophy of 'easy access into care, easy out and easy back in'.
- High level **expertise** of senior clinicians at the commencement of and throughout an episode of care.
- An inclusive and proactive approach through **consultation** with individuals in relation to family/carer involvement, with connection established early and maintained at all points along the continuum of care.
- A **paradigm shift** in sharing information and enabling individual's families and carers to be active participants in decision making.
- **Evidence-based care** and **best-practice** in key clinical domains.
- **A focus on enhancing integration** and **collaboration** with key partners, in particular PDRSS/CMMHS and GPs.
- More opportunities to **develop a consumer and carer workforce** as a formal discipline, giving consumers and their families/carers wider choices about service options and experiences of care, including routine access to peer support workers.

Within our *Framework for Care,* the care we offer individuals and their family/carers is conceptualised as occurring across 3 pathways of care; a targeted brief intervention pathway, a longer term pathway and a consultative response pathway. Within these additional responses, including an urgent response to a crisis, an increase in the need for intensive support or medication support may be required and provided at any time. The diagram below outlines a conceptual map of responses and supporting functions.

Pathway to care

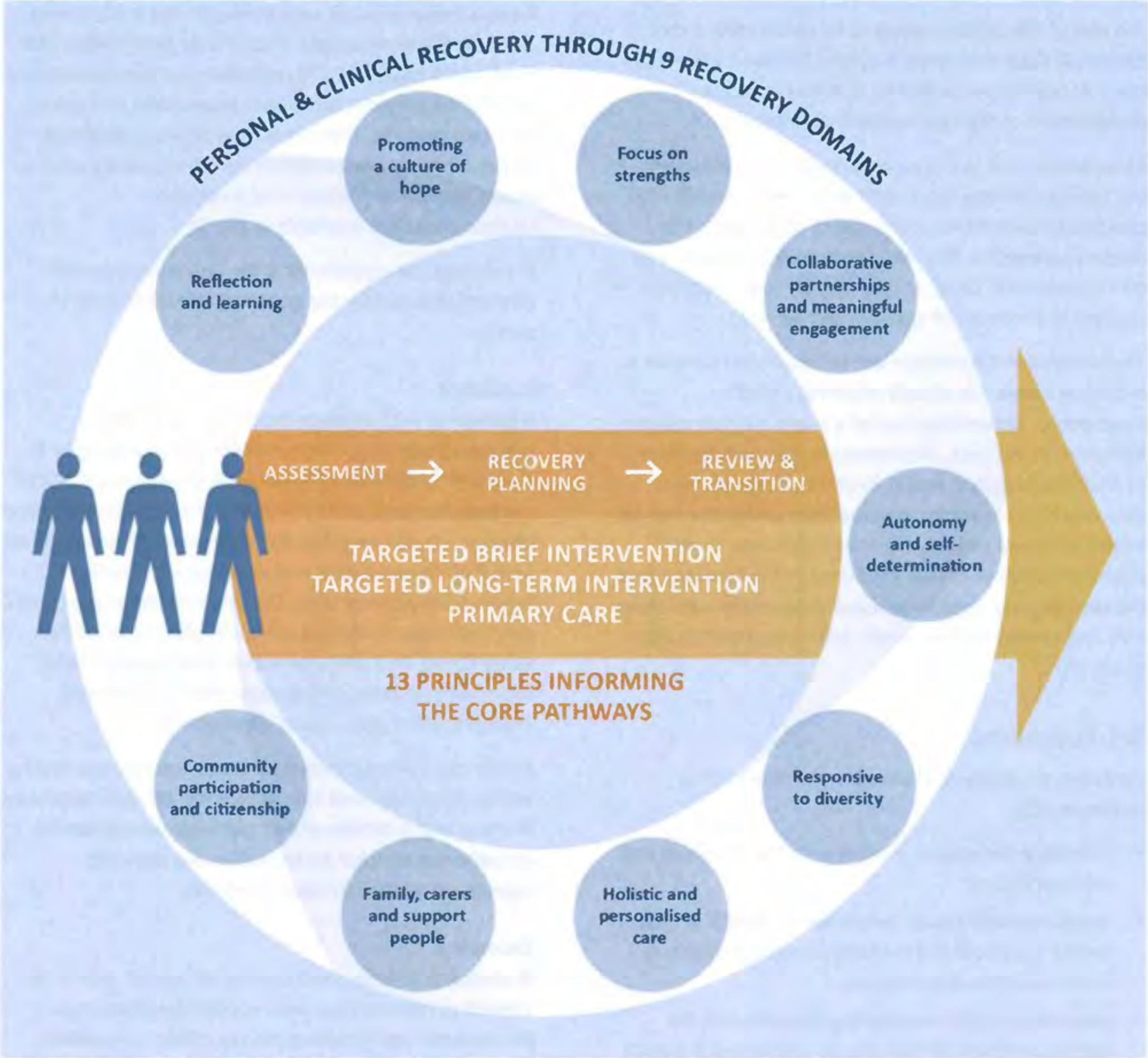


The pathways are articulate to include the following:

- **Targeted brief interventions:**
  Within the targeted brief intervention pathway, after the face to face assessment, clinicians will develop a joint recovery plan which is based upon the needs and preferences of the individual and their family/carers. The plan will outline the focus of the clinical interventions over the coming weeks and 1-2 months. The focus of care is likely to include linkage to primary care supports, psychoeducation, short term therapy and medication support.
- **Targeted longer-term interventions :**
  Within the targeted longer term intervention pathway, after the face to face assessment, clinicians will develop a joint recovery plan which is based upon the needs and preferences of the individual and their family/carers. The plan will outline the focus of the clinical interventions and the likely timeframe over months and possibly years.
- **Consultative responses to primary care providers**
  While communication with primary care providers is expected to be a routine activity throughout all care provided, the purpose of this dedicated response is to enhance the capacity of primary care providers to recognise and treat mental health disorders in the community, through specialist assessment, consultation, and provision of advice, education; and facilitating the linking with other service providers. This response will be targeted to particular individuals, and is likely to be predominantly provided by senior clinicians, consultant psychiatrists or senior registrars, or any clinician who may have been previously involved in the care of the individual to whom the request relates.

The overall framework is supported by the nine overarching recovery domains, thirteen principles of care which inform the three core pathways. See diagram on page 21.

Recovery domains principles of care and pathways



Adapted from the Department of Health, Victoria, 2011. *Framework for recovery – oriented practice*

5. Role of the clinician

The role of the clinician needs to be considered in the context of the enhancement of the Community Managed Mental Health Services (formerly PDRSS) and the development of the Peer Support workforce.

As secondary and tertiary mental health care providers our services provide specialised expertise to people with complex presentations, and we work closely with the primary care sector. The lead service will be determined on a case-by-case basis, as care may be coordinated by any one of a number of agencies and services.

The function of the clinician will be flexible in response to individual needs. For people receiving a brief intervention, the involvement of a single clinician may be sufficient. In this case, the clinician will undertake some or all of the functions below. In other situations more than one clinician will be involved from within the mental health team and possibly from other services. In an intensive period of clinical involvement it is expected that the clinician may need to increase involvement with more frequent contact and/or recruit extra support from after-hours staff.

5.1 Functions

Functions of clinicians, explored in the case studies below, include:

- building a therapeutic alliance with the individual and the family/carer
- being a contact person within mental health services for the individual and the family/carers, to assist in communication and planning
- understanding the needs and preferences of the person and their family/carer by conducting a mental health assessment which leads to the development of a recovery and wellness plan which guides care and treatment
- delivering targeted interventions
- understanding the individual and their family/carers in the context of their existing social network and support systems
- coordinating care with external service providers
- ensuring completion of the clinical governance, legislative and documentation requirements, for example clinical review discussions, documentation, and adherence with the Mental Health Act and other legislation.

Example 1
A consumer previously seen at the service is displaying some early warning signs. The GP asks for a review and medication guidance. The consumer and family/carer are seen by the previous consultant psychiatrist for review over two sessions. The psychiatrist provides feedback and guidance to the consumer and family/carer, and makes the review findings and medication recommendations available to the GP.

In this case the psychiatrist is the only mental health clinician required for the response and is the contact person.

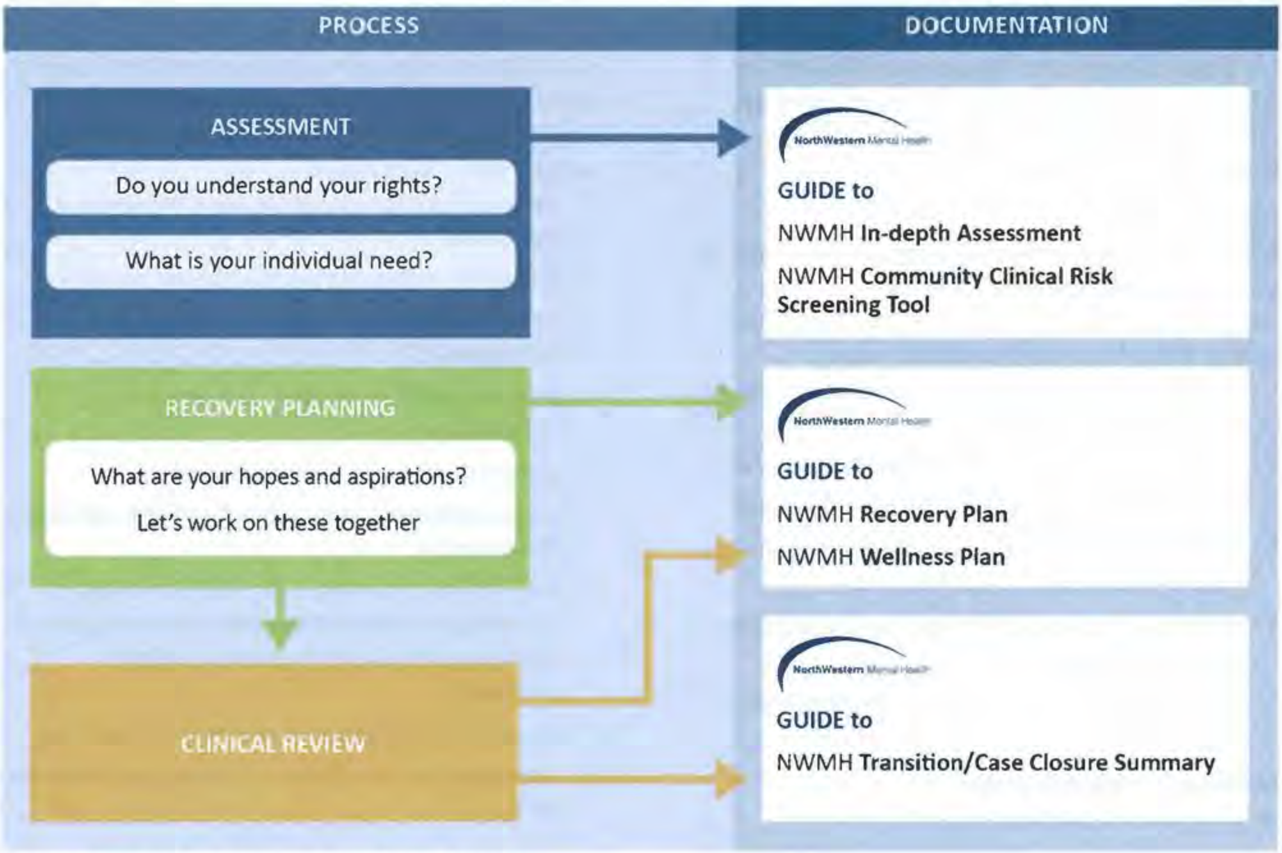
Example 2
A consumer with complex needs has input from a number of agencies. The mental health psychologist is the AMHS clinician and liaises with the psychiatrist from the inpatient unit, ECATT staff and the CL Manager when required, as well as attending case planning meetings on behalf of mental health and developing the mental health management plan. The psychologist also provides psychotherapy to the consumer. The Justice Disability worker from DHS provides overall case management, addressing housing, finance and MACNI issues and engaging other agencies as appropriate.

In this case the psychologist is the contact person liaising within the service and links with other services, providing therapy to the individual and specialist mental health consultation to other stakeholders, but does not coordinate all the individual's services.

Example 3
A consumer is being seen by a social worker who is the contact person and has been providing individual and family/carer interventions around relapse prevention. The consumer would like to engage in some work on managing treatment-resistant symptoms. The social worker requests the assistance of a nurse on his team who specialises in this work, and the nurse provides five months of focused interventions.

In this case the social worker and nurse provide targeted/specialist interventions with the social worker providing the mental health coordination, accessing other specialists as clinically indicated.

The clinician's role within assessment and recovery is guided by the principles of care outlined in Section 3. The initial assessment should gather as much information as possible at the time, in the process outlined in the diagram below.



Click on iPolicy to find the guidelines for each process.

5.2 The foundations of recovery practice

The principles of care outlined in Section 3 of this Guide provide the framework for engagement, assessment, formulation and recovery planning. These are based on the following core skills or activities being provided by the clinician.

Therapeutic alliance

Establishing and maintaining a therapeutic relationship is based on respect and sensitivity, with particular attention to culture and gender. Establishing the therapeutic alliance includes:

- engaging the individual and the family/carers
- establishing clear boundaries
- negotiating the sharing of information and the limits of confidentiality.

The process of clinician engagement is:

- fundamental to developing a therapeutic alliance
- often complex
- central to supporting the individual's recovery journey
- potentially a very rewarding element of a clinician's professional work.

Essential elements of therapeutic engagement are those of any healthy human relationship – trust, hope, respect, commitment, honesty and clear boundaries. Hold hope for the individual's future and share your image of hope with them and their family/carer. Use a language of recovery that promotes hope, fostering known and unknown strengths and resources. Earn the trust of the individual and family/carers. Communicate clearly, keep them informed, and be available and supportive. Acknowledge personal skills and abilities.

The relationship is different to a friendship, as both people in the relationship are working on the needs and goals of only one person. The clinician has a duty of care to maintain a therapeutic boundary with the individual, and is responsible for ensuring the individual is aware of the purpose and nature of the therapeutic relationship. This mixture of formal and informal interactions can test the boundaries of the therapeutic relationship, so the clinician must be competent in therapeutic engagement and well supported with supervision.

Trust the individual and family/carer, assist them to generate options, and support them to make choices. Help identify things and activities that are enjoyable and fun. Create an opportunity for authentic feedback and dialogue, and reflect on achievements and challenges, without ignoring issues that are difficult to discuss. Finally, celebrate successes.

Communication

Effective verbal and non-verbal communication skills help build the therapeutic alliance. They can encompass interviewing techniques, negotiation skills and problem solving. Tools of good communication include:

- empathy, being able to imagine the experience of the individual and family/carers
- acknowledging and normalising feelings of unease
- good listening skills, following the individual's lead
- reflecting back, asking questions that explore the issue and clarifying that you have understood
- respecting the person's life experience, knowledge and understanding
- valuing the individual's resilience, coping strategies and strengths.

Collaboration and partnerships

An ability to work collaboratively with individuals, families/carers and with other health professionals is an essential skill. It allows clinicians to assist the individual to establish – and re-establish - supportive relationships while acting as an advocate and looking after the individual's best interests. Collaboration requires clinicians to work sensitively, responsively, respectfully and collaboratively with the person and their support networks. Collaborative practice optimises personal choice and flexibility, and focuses on openness, equality and the individual's strengths.

Assessment

Assessment is a core functional component of service delivery which assists the planning and monitoring of care from the point of entry to the service to the point of transition. Assessment should be collaborative, inclusive of all partners and recovery-focused. Mapping the social networks of the individual and family/carer allows early identification of the person's strengths and linkages.

Goal setting and planning

The process of goal setting and planning aims to align the service needs and goals with the individual's recovery goals. It should support the individual and family/carer in goal-directed planning that is based on strengths, working together on the individual's recovery and wellness plans. Steps include:

- exploring the person's options and understanding their wishes
- guiding the individual's journey towards recovery
- taking into account the goals of a collaborative relationship
- promoting self-management and personal responsibility
- promoting medication self-management
- balancing symptom management with the side effects of medication
- maximising the learning, over time, by individuals, families/carers and clinicians about the biological and psychological impact of medication and their preferences
- providing an individualised approach to treatment
- accounting for the culture in which you undertake the tasks.

Coordination

Coordination of care, which can be challenging, requires detailed team planning and effective communication. It encompasses a coordinated and tailored approach for people who require support from multiple services and a consistent team response to the individual at every stage in the continuum of care. Factors that can contribute to better coordination of care include:

- ensuring that services are accessible
- providing flexible programs
- linking to other agencies
- understanding the development of social networks
- being able to initiate appropriate referrals.

Legal requirements

Legal obligations to consumers must account for the concepts of risk tolerance and balancing risk, while empowering individuals within a safe environment and within the parameters of the duty of care. It is necessary to recognise the continued tension between 'positive risk-taking' while promoting safety. Clinicians must be familiar with relevant legislation including the Mental Health Act and the Children, Youth and Families Act, and also be familiar with their duty of care, the issues of consent and confidentiality, and statutory and legislative requirements including the need for documentation. They must ensure they have appropriate clinical training as defined by the standards of their profession.

5.3 Victorian Recovery Framework: expected clinician capabilities

The Victorian Recovery Framework defines the capabilities that clinicians need to demonstrate within their recovery-orientated practice. Throughout the nine domains of recovery, mental health workers need to be capable and competent in their knowledge and understanding of the philosophy which informs each principle. The knowledge includes understanding the personal resourcefulness of the individual, accommodating the diverse views on mental illness and treatments, and advocating for individuals to make an informed choice. All clinicians are expected to have knowledge about the major types of treatment, therapies and targeted interventions and how these contribute to recovery-orientated practices.

Our aim is to strive as an organisation to excellence in recovery-orientated service delivery. The expected capabilities are embedded within our recruitment processes and the Workforce Learning and Support strategy to ensure that mental health workers understand their role within the service. We strongly suggest that you read through the key capabilities under each specified domain of the Victorian Framework for Recovery-Oriented Practice and revisit your position description – *Accountabilities.*

Part three:
Guide to treatments, interventions and approaches for disorders

Part three: Guide to treatments, interventions and approaches for disorders

6. Choosing treatments and services

6.1 The decision-making process

National and State guidance on recovery frameworks and standards of professional practice set the context for engagement and clinical decision-making (Department of Health and Ageing - National standards for mental health services 2010).

Collaboratively-agreed priority goals or problems are the starting point for individual service planning. *Goals* are the desired changes that can be achieved in a realistic period of treatment or care, for example resuming normal activities after a relapse with residual symptoms. *Difficulties* are impediments to normal or desired functioning that need to be explored and resolved, such as medication side effects that discourage regular use of otherwise helpful medication.

Decisions about services and treatments consider the following questions:

1. Is an evidence-based treatment guideline for this problem available?
2. What treatments and services are recommended by the relevant guideline?
3. How well does any recommended treatment fit the individual characteristics and circumstances of the individual?
4. What is the preference of the individual and the family/carer for any possible treatments?
5. Do we have available expertise and resources to offer a recommended treatment?
6. Are there any organisational policies, procedures or restraints that need to be taken into consideration.

Evidence-based treatments or services are a priority but are not necessarily available, and do not cover all aspects of our work. Many factors contribute to wise decision-making about treatments. Knowledge about an 'evidence-based treatment' or 'empirically-supported interventions' does not mean automatic application of a recommended treatment: each of the six factors above needs to be weighed in consultation with the individual, family/carer and team.

Guidelines exist for many aspects of mental health care and are introduced in Section 8. The guidelines do not address all aspects of care, they do not exist for all presenting mental health problems, and they often fail to deal with comorbidities and complex presentations. However, when a relevant guideline does exist, it should be given high priority in decision-making.

If alternatives to evidence-based treatments exist, they must be thoughtfully considered. For example, if no relevant treatment is recommended by a clinical practice guideline, or when an individual and/or family/carer wishes to consider an alternative treatment, the proposed approach should be assessed by factors including:

- the similarity of the alternative to a recommended treatment
- the existence of any emerging external evidence (such as published evidence not yet considered by clinical practice guidelines)
- any evidence of safety or of low risk
- local evaluation (for example, formal evaluations in NWMH)
- local experience (for example, previous use of the treatment in NWMH)
- the existence of a promising innovation with a persuasive rationale.

Individual and family/carer experience and preferences are valued in decision-making. Their previous experience of recommended or alternative treatments should be discussed and considered, including perceived effectiveness, and unwanted side-effects.

Any lack of expertise or resources should prompt consideration of alternative providers or treatments, for example access to the treatment or service available through an external providers, the use of a similar treatment, or offering a briefer or more limited version of the treatment or service.

6.2 Factors influencing the experience of mental health

An individual's experience of mental health, including their vulnerability and risk of trauma, is influenced by a number of factors that should be considered in planning their care. These include:

Aboriginal and Torres Strait Islander heritage
Information about the Aboriginal Service Development Worker (content under development)

Cultural and/or linguistic diversity
(content under development)

Previous experience of trauma
A woman in her fifties who usually does not miss appointments has been difficult to contact and has missed several appointments. This change is considered to relate to her deteriorating mental health. When she is admitted into the emergency department with a broken shoulder, it becomes clear that she has experienced escalating partner violence over the past few months and was not allowed to attend appointments.

A young man is referred to a mental health service and when it is suggested that his family is involved (as is good practice), he becomes distressed. The fact that he had experienced childhood sexual abuse by a family member was not discussed during the assessment phase.

People with mental illness experience high levels of interpersonal trauma and trauma impacts on mental health. Traumatic experiences can impact on a person long after they occurred, can be overwhelming and can include profound impacts on neurological (brain development in children) and psychological development, as well as on a person's emotional, biological and interpersonal development (van der Kolk, 2005; Perry et al 1995). Women are more likely to have experienced interpersonal violence and trauma and often have multiple times; while men with mental illness experience less violence from partners or family members, increasingly it is known that they experienced high rates of childhood sexual abuse.

A move towards providing mental health care that is ***trauma informed*** is going to assist in working in a way that is sensitive and thoughtful about trauma. On an individual clinician level there is much that can contribute towards engaging well with people who have experienced trauma.

Some strategies that may assist: know that

- more likely than not the person you are working with has experienced trauma
- traumatic events are highly likely to have impacted on the person
- people can experience a range of reactions that relate to past trauma and this is not always obvious to clinicians
- people who talk about trauma experiences from the past will not necessarily need or want specific follow up about their experiences frequently they want to be heard, listened to and supported
- conveying understanding that past trauma can still impact now and normalise responses can assist
- adaptive behaviour and coping strategies are likely to have assisted the person for a long time, understand their coping strategies and assist in changing these if they have become problematic
- it is important to inquire about current safety (in their relationship, life) and assist in increasing safety if you are able to do so (consult with family violence, sexual assault services to get some assistance)
- it is not always appropriate to ask about (previous) trauma, if in doubt, talk to a clinician experienced in this area of work (or a specialist service) and/or seek input about when, how and why to ask
- you can seek assistance from staff experienced in working with trauma and/or senior staff; consider consulting with organisations that specialises in sexual assault, family violence or trauma work

Gender Sensitive Care
A woman tells a staff member that she is being followed by a male patient and nobody seems to worry about it. .

A man in his forties has been a consumer at the clinic for sometime. One day another consumer makes a loud announcement in the waiting room that he used to be a she and that she should stop pretending to be a man.

Gender sensitive care means that gender is taken into account and a focus on increasing sensitivity and safety for those identifying as women, men, transgender and intersex is part of everyday clinical care (Department of Health, 2011). Gender is a key marker of identity; it is a strong predictor of health and wellbeing outcomes. Combined with other social and cultural characteristics such as cultural identity, sexuality, age, ability and disability or whether the person is a parent (see sections Aboriginal and Torres Strait Islander, CALD, trauma and family work), gender determines many mental health and social emotional wellbeing outcomes.

Strategies that may assist in clinical work are:

- Awareness and knowledge about the level of discrimination, trauma and interpersonal violence experienced and its impact on women, men, transgender, intersex, gay, lesbians, bisexual people and the connection to mental health problems (see also section trauma)
- Knowing about the high levels of childhood and adulthood abuse and violence people with mental illness have experienced and increase skills, knowledge and awareness about how to engage about trauma in a sensitive way
- Taking a diversity lens: appreciating commonalities and being interested about differences between people who ***seem*** to have the share characteristics or backgrounds
- Considering the lack of safety in bed-based services: many people – for many reasons – do not feel safe in bed-based services, ensure that safety is discussed, assessed, monitored and increased as much as possible
- Being alert to discrimination and social exclusion that many people continue to experience, not contributing to further discrimination
- Consulting the service guideline on gender sensitivity and safety (Department of Health, 2011) and seek input and advice from colleagues if uncertain about a 'gender' related issue or situation

Physical disability

(content under development)

7. Evidenced-informed strategies applicable to a range of disorders

A number of evidenced-informed strategies, including those described below, are applicable to a range of mental health disorders. The strategies included are based on the frequency of use with individuals seen within adult services and are summarised in the section below commencing with key collaboration.

7.1 Key collaborative strategies

Many collaborative strategies are familiar elements of counselling practice, cognitive behavioural therapy and other therapies. Family/carer information and engagement, and peer support interventions and programs, are also widely applicable across disorders, and are discussed in more detail in Sections 7.2 and 7.3.

Problem solving (and teaching problem-solving skills)

Problem-solving skills include:

- discussion leading to clarification of the problem
- summarising the problem in writing, using agreed words
- brain-storming several alternative ways of addressing the problem
- discussing the pros and cons of each alternative
- prioritising the solutions
- making a decision.

Self-monitoring of experiences and behaviours

Keeping a record of when problem experiences occur, the setting, and the person's response (behaviour, emotions, thoughts) can not only assist further assessment, but also enhance self-regulation and prompt reflection on how to cope better.

Goal setting

In the context of a desired or needed change, it is helpful to agree on one or two 'SMART' goals:

> <u>S</u>pecific (who will do what)
>
> <u>M</u>easurable (how will we know it has been reached?)
>
> <u>A</u>chievable (realistically able to be achieved in the time frame)
>
> <u>R</u>elevant (how will this help, given the problem or direction of desired change?)
>
> <u>T</u>ime-limited (when will it be achieved? - usually within the anticipated period of care).

Personalised psychoeducation

Personalised psychoeducation can include:

- providing information about the disorder
- helping the individual to make links between their personal experiences and information about the disorder
- exploring attitudes towards the disorder 'label'
- helping the person come to terms with having a mental health disorder or vulnerability, including discussion of their personal experiences (this step does not necessarily require full acceptance of the psychiatric concept of the disorder).

Activity scheduling ('behavioural activation')

Activity scheduling helps the individual to increase the frequency of valued or pleasurable behaviour through systematically reinforcing (rewarding) desired activities and minimising any negative consequences of the activities. For example, the clinician and individual may:

- record all activities each hour of the day for a week
- identify current and past rewarding activities to create a hierarchy of reinforcing activities in order of difficulty and decide on the rewards for taking action
- schedule activities for the coming week
- troubleshoot any aversive consequences of participation (for example, anxiety)
- support the individual in monitoring progress and moving through the hierarchy of activities.

Coping strategies ('coping strategy enhancement')

Developing coping strategies is a collaborative process in which clinician and consumer collaboratively:

- identify and list the person's 'natural' coping strategies for a specific stressor (regardless of whether they are automatic or deliberate, helpful or unhelpful)
- clarify the degree to which these help the consumer *feel* better (emotion-focused coping) and/or *reduce the problem* itself (problem-focused coping)
- brain-storm possible improvements to existing strategies (for example how to recall when needed) and/or alternative or additional ways of coping with this situation, and consider the consequences of different coping strategies
- review and refine strategies over time.

Identifying early warning signs (EWS) and developing a relapse prevention plan

This process can range from a brief informational intervention to formalised 10-session therapy. Key ingredients include:

- recall of early signs that occurred before the last acute episode of the disorder
- where possible, ordering these warning signs according to whether they were early or late
- identifying ways of coping with these experiences through self-management and professional assistance
- planning what actions the person will take and negotiating with family/carer or others on what actions they should take if early warning signs become apparent in the future
- shaping the process as a positive development in self-management, and taking care to avoid undue or pessimistic self-monitoring.

Working with advance statements/directives (pending)

This section will be developed in line with the new mental health legislation for Victoria. Our aim is to work collaboratively with individuals and their families/carers, support the decision to make an advanced statement for their treatment preferences (Mental Health Act - New Reforms), and work collaboratively to incorporate it within the individual's wellness planning.

Social network mapping

The social network mapping tool 'Eco-mapping' is grounded in strengths-based client-centred practice. It is a collaborative assessment tool that visually demonstrates an individual's linkage to their support system and allows comparisons of these systems as they evolve over time. It is given to the person as a take-home example of their current life domain map, and used to highlight their existing formal and informal support network. The tool helps to clarify needs and gaps in the individual's social system, and assess the issues facing family/carers regarding their own access to support, the quality of their relationships, their needs and their linkage options. Eco-mapping can be applied throughout the continuum of care, whether in brief psychotherapeutic and community linkage interventions, at points of crisis, in assessment of need, and in engagement, planning and review with medium- to longer-term consumers and family/carers.

Relaxation

Relaxation is a practice useful for short term coping with everyday situations which may cause stress and anxiety. It can be usefully applied by almost anyone in everyday life, as well as having the power to enhance outcomes for people with mental health conditions. Examples include:

- Relaxation through a focus on breathing techniques such as: noticing your breathing, taking slower or deeper breaths, and being aware of relaxing each time you breathe out
- Relaxation through progressive muscle relaxation, which may proceed by learning to relax specific muscle groups, then systematically applying this to the whole body
- Guided imagery. A worker prompts the cons8umer to create a detailed image of a personally relaxing, peaceful scene

Mindfulness (pending)

Sensory Modulation

Sensory Modulation is regulation of arousal levels (elevated and decreased) in any given situation. Sensory modulation considers all sensory systems, namely; visual, auditory, olfactory, gustatory, touch and three internal senses; proprioception (body awareness), vestibular (movement and balance) and deep pressure.

Sensory Modulation assessment and intervention are evidence informed modalities of treatment and care.

Sensory Modulation could be helpful for individuals where there are any sensory processing difficulties. These would be gleamed through assessment.

In particular sensory assessment and treatment should be provided to people:

- If clinicians hypothesize that the consumer's sensory system may be influencing their functional performance ie, where sensory stimulus appears to significantly influence a persons activities of daily living;
- To increase consumer's coping strategies to modulate their emotions;
- To assist consumers in modifying their home/work/study environments to maximize their functional performance;
- To assist consumers develop a personal safety plan to utilize at times of crisis and/ or if hospitalized;
- To assist consumers with complex needs in developing and utilizing an individualized self regulation kit.

Interventions offered include specialist assessment, education, and development of a sensory kit, sensory diet and group work. Evidence for the interventions include both local and research based studies (see the reference section for a list of relevant literature).

7.2 Interventions for families/carers

Evidence-informed and evidence-based family/carer engagement, assessment, supports and intervention is applicable to a range of disorders, across phases of illness and recovery. The interventions are also applicable to families in which a parent with dependent children has a mental illness (FaPMI).

The diagrams (7.2 a-c) summarises the universal and targeted interventions that have been described in the literature and evaluated in current NWMH practice. The options include those primarily delivered within community teams by the clinical workforce and the carer peer workforce. Interventions can be offered:

- internally to NWMH individuals and their families/carers
- through inter-agency collaboration to shared client groups
- by external agencies via linkage or referral.

Family/FaPMI/carer practice

This area of practice has been termed '**Family/FaPMI/Carer Practice**' to ensure that a narrow concept of family is avoided and the differing family constellations and meanings of 'family focused' and 'carer support' are explicitly overted to prevent any component, role or relationship in the family being hidden or unattended to.

This area of practice acknowledges all of the following:

The **consumer** as a:

- **member of a family of origin** in its varied forms – through birth, adoption, fostering, blended, community of culture/kinship, whether as a child/offspring, sibling, step-sibling, aunt/uncle, cousin, grandparent, ***Whānau***
- **partner or spouse** in a family of choice or procreation across its various constellations, for example marriage, same-sex, de facto relationship/commitment
- **parent of a dependent child/young person** (0 to 18) across the varied arrangements of responsibility for child rearing, child support, custody/access, guardianship etc.

Family members of the consumer who are from:

- the **family of origin**, for example parents by birth, adoption, remarriage
- the **family of choice/procreation**, for example:
  - adult – husband, wife, spouse, de facto, same sex partner
  - child/young person - biological, adopted, step daughter/son including dependent children (0-18) and adult children
  - significant others regarded by individuals as close supports/friends (other than 'paid' carers who would be regarded as key external partners in the treatment system).

The impact of illness and disability on relationships is a significant factor in the experience and recovery of individuals. Whether family members identify with or reject the term 'carer' is irrelevant to their right to be involved in the treatment partnership, and/or to receive support to meet their own needs. This includes both children and young people who may or may not identify as a 'young carer'.

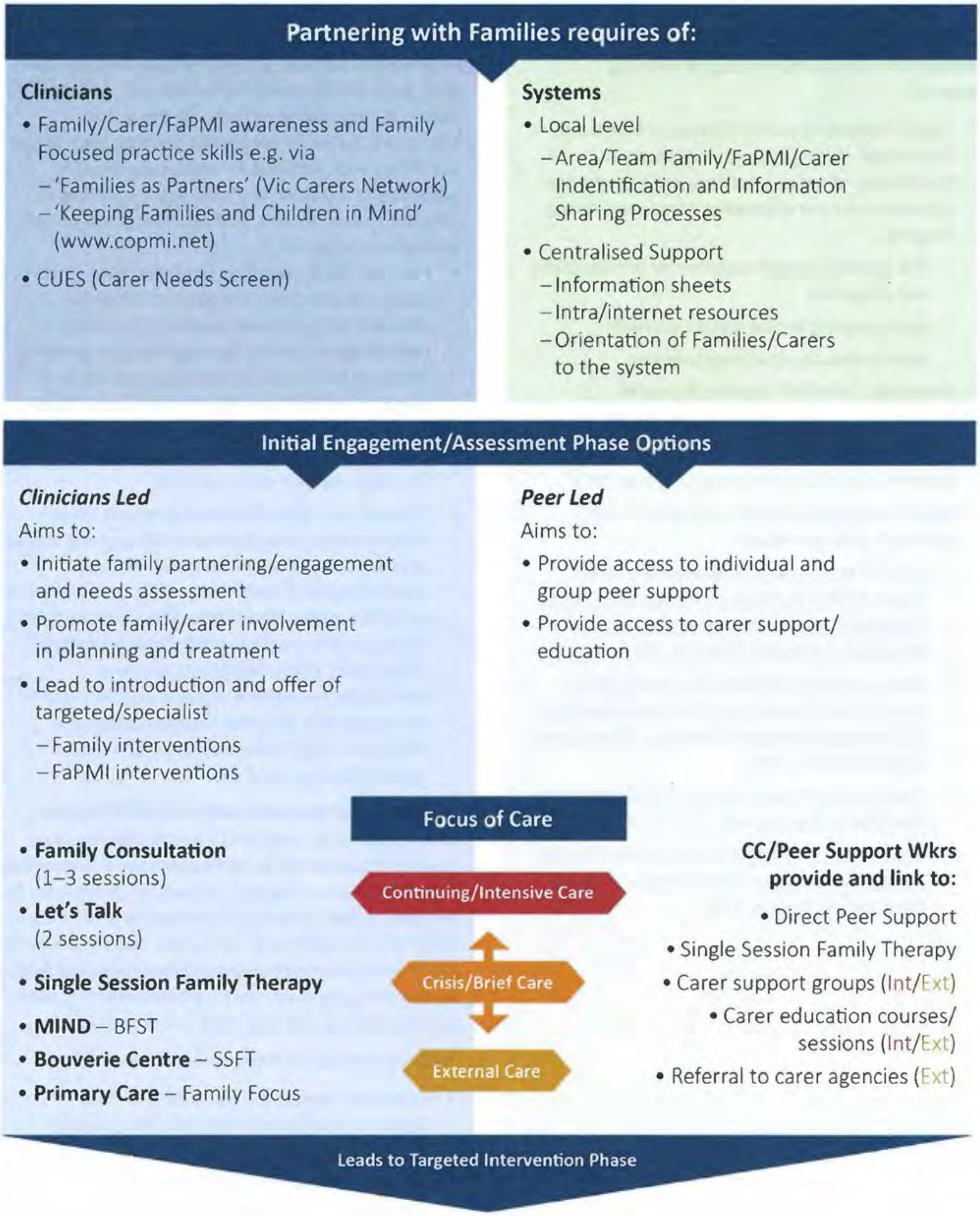
A FaPMI focus

There is a need for active attention to the parenting role in the recovery of individuals, including the relationship between consumers and their dependent children and the needs of those dependent children. Interventions specifically designed for parents and their dependent children have a solid evidence base (COPMI Gems), and they should be at the core of a recovery-based and evidence-informed service.

The fundamentals of partnering with families

Attitudes, values and expectations underpin effective partnership with families (Figure 7.2a). Two foundation level learning resources are available for clinicians to develop the appropriate foundation level awareness and skills: 'Families As Partners in Care' (a team-based face-to-face education program developed by The Vic Carers Network) and 'Keeping Families and Children in Mind' (a supported training/e-learning resource developed by the National COPMI Initiative). Initial and periodic reviews of adult family/carer needs can be supported by the CUES survey (Elliot et al 2003).

Diagram 7.2a – Evidence Based/Informed FAMILY, FaPMI, CARER Practice & Intervention Map



Partnering with Families requires of:

Clinicians

- Family/Carer/FaPMI awareness and Family Focused practice skills e.g. via
  - 'Families as Partners' (Vic Carers Network)
  - 'Keeping Families and Children in Mind' (www.copmi.net)
- CUES (Carer Needs Screen)

Systems

- Local Level
  - Area/Team Family/FaPMI/Carer Indentification and Information Sharing Processes
- Centralised Support
  - Information sheets
  - Intra/internet resources
  - Orientation of Families/Carers to the system

Initial Engagement/Assessment Phase Options

Clinicians Led

Aims to:

- Initiate family partnering/engagement and needs assessment
- Promote family/carer involvement in planning and treatment
- Lead to introduction and offer of targeted/specialist
  - Family interventions
  - FaPMI interventions

Peer Led

Aims to:

- Provide access to individual and group peer support
- Provide access to carer support/ education

- **Family Consultation** (1–3 sessions)
- **Let's Talk** (2 sessions)
- **Single Session Family Therapy**
- **MIND** – BFST
- **Bouverie Centre** – SSFT
- **Primary Care** – Family Focus

Focus of Care

Continuing/Intensive Care

Crisis/Brief Care

External Care

CC/Peer Support Wkrs provide and link to:

- Direct Peer Support
- Single Session Family Therapy
- Carer support groups (Int/Ext)
- Carer education courses/ sessions (Int/Ext)
- Referral to carer agencies (Ext)

Leads to Targeted Intervention Phase

Each AMHS will need to clarify and establish family/carer/FaPMI identification and information sharing processes. Centrally, at NWMH level, development and maintenance of organisation-wide resources will support clinicians and peer workers. These clinician and system developments can be informed by the following resources:

- 'Carer Perspectives on Identification of Carers and Their Needs' (Appendix 12.7) outlines the identification of needs, identifying and engaging key partners in care and negotiating information sharing including:
    - first and early contact questions for families/carers and consumers
    - during ongoing service contact questions
    - prior to transition/discharge questions
- MWAMHS - Let's Work Together Principles
- NAMHS - Working Together with Families and Carers Practice Principles
- IWAMHS - Family Carer Working Party Plan 2013.
- State & National Best Practice documents with significant guidance include:
    - National Mental Health Individual and Carer Forum (NMHCCF), Position Statement on Privacy, Confidentiality and Information Sharing – Individuals, Carers and Clinicians, 2011
    - Australian Infant Child Adolescent and Family Mental Health Association, Principles and Actions for Services Working with Children of Parents with a Mental Illness; 2004
    - Department of Health, Victoria, "Chief Psychiatrist Guideline on Working with Families" 2005
    - Department of Human Services, Victoria, Families Where Parents Have a Mental Illness – A Service Development Strategy, 2007

Engagement, assessment, intervention and support options

Each AMHS will need to assess their strengths and gaps in engagement, assessment and intervention/support options and build capacity where gaps exist. Families/carers should routinely be made aware of both peer- led and clinician-led intervention and support options during orientation to the service and as appropriate during service contact, allowing them to 'opt out' if they wish. Adopting an 'opt out approach' is preferable to access being offered at the discretion of clinicians or peer workers. Staff should regularly re-visit any decision to opt out.

- Peer Led - Carer consultants and carer peer support workers directly provide support or linkage to individual and group peer support, education and external agency referral options. These are primarily offered or led by workers with lived experience of caring for an individual with a mental illness. These are offered at any time including post transition from care rather than being restricted to an episode of care or within a defined catchment area.
- Clinician Led – While intervention options led by clinicians share some features similar to those offered as carer support they are primarily FPE clinical interventions with evidence for effective outcomes at particular points of the service delivery continuum. In this phase they focus on initiate family partnering/ engagement, needs assessment, promote family/carer involvement in treatment. They lead to the introduction and offer of targeted/specialist Family and FaPMI interventions alongside carer support (See figures7.2 a-c).

Recommended Targeted Family and FaPMI Options

Family psychoeducation (FPE) is a term that describes structured approaches to working with the individual and their family/carer to support recovery. FPE is informed by the stress-vulnerability model and focuses on developing a shared understanding of explanatory models, providing information about mental illnesses (including identifying early warning signs) and teaching family members about problem-solving, communication and coping skills.

Targeted Intervention Programs are designed for:

- family members/carers themselves, without consumer involvement, e.g. Carer Peer Support Groups, CHAMPS
- the whole family inclusive of the consumer e.g. Family Consultation, Building Family Skills Together
- the consumer and a part of their family e.g. Supported Play Group
- the consumer as a family member e.g. Let's Talk

Diagram 7.2b – Recommended Targeted FAMILY Intervention Options

Title of Evidence based Model	Target Cohort & Phase	Evidence	Current NWMH Expertise	Inclusive of Consumer?	Inclusive of Peer Leader?	Delivery – Internal Plus • Interagency? • External agency?
Family Consultation* (FC)	All Families of Consumers accepted for ongoing care; Prioritise early in service relationship	USA Consumer Centered Family Consultation – Program Evaluation Jewell et al; Dausch et al 2012; Bouverie Centre Beacon Project Evaluation 2012	• NAMHS – 2 clinician model MFG/BFT engagement phase hybrid; CCT/MST/CCU since 2005; • MWAMHS – single clinician Beacon/SSFT hybrid CCT since 2011 • IWAMHS – 2 clinician model MFG recruitment/ engagement phase;	YES	• No • Carer Consultant in Grp Supervision sessions	• Internal • Possible to include partner agencies with shared clients
Single Session Family Therapy (SSFT)	Any Consumer & their family; Acute Phase or those not seen by service for ongoing care & referred externally	Hymmen 2013; Young et al, The Bouverie Centre 2012; Perkins et al 2008	• NAMHS – CATT since 2010/PARC 2013 PhD Candidate	YES	No	• Internal • Possible to include partner agencies with shared clients • Offered by Bouverie Centre
Behavioural Family Therapy (BFT); Building Family Skills Together (BFST)	Single Family Model Any Consumer & their family; *At any phase following FC.* **	Behavioural Family Therapy – BFT • UK – Fadden/ Meriden • AUS – NWAMHS/ Bouverie	• NWAMHS • NWAMHS 2012 Introduction via Beacon	YES	Possible co-facilitation with Clinician	• Internal • Liaison with external delivery by BSFT MIND
Multiple Family Group (MFG)	Multi-Family Model Any Consumer & their family & Alliance partners *At any phase following FC.* **	• USA – McFarlane • IWAMHS 3yr Research Pilot Findings • NAMHS 2008	• IWAMHS research pilot 1997–2001, anually since 2009/ Graduates Grp since 2012 • NAMHS 2008	YES	Possible co-facilitation with Clinician	• IWAMHS Invite to Alliance partners since 2011

*Initial Engagement/Needs Assessment Focus preceding 'Specialist/Targeted interventions'; **For Discussion according to Area capacity to offer FC initially

Diagram 7.2c – Recommended Targeted FAPMI Intervention Options

Title	Target Cohort & Phase	Evidence	NWMH Expertise	Inclusive of Consumer?	Inclusive of Peer Leader?	Delivery – Internal/Interagency /External
Let's Talk*	Any Consumer Parent with dependent children 0–18; Versatile re Phase	RCT – Solantaus et al 2009/2010 Finland	• NAMHS/NEAMI Pilot 2011–2013	YES	NO	• Internal • Possible with partner agencies
Family Focus	Any family where consumer with Depression or Anxiety has dependent children 0–18; Post Acute Phase	RCT – Family Talk Beardslee et al 2007 USA	• Nil	YES	NO	• Possible to offer internally • External Primary MH Care Sector
Parents Group	Any Consumer Parent with dependent children 0–18;	Mayberry et al 2006; Parents Grp Eval (2003–2012) Fernbacher et al;	• NWAMHS GELS Grp; • NAMHS Annual Nthrn Parents Grp 2003–2012; IWAMHS Family Recreational Activities since 2005	YES	YES	• Interagency Collaboration required
Supported Playgroup Group	Playgroups for Consumer Parents and children 0–5; Post Acute Phase	Scoping Study. Ablser, 2009 Goodyear, Fernbacher Evaluation Report (2012; and 2013 forthcoming)	• Our Time Supported Playgroup 2011–2013 School Terms	YES	YES	• Interagency Collaboration required
CHAMPS School Holiday Peer Support Program	Any children 8–12 of Consumer Parents	VicCHAMPS Pilot Program Evaluation 2003–2006; Mayberry et al 2006;	• NAMHS Annual 2006–2012; • MWAMHS Annual since 2012 – Brimbank & Melton	NO NO	YES YES	• Interagency Collaboration required
PATS Peer Support Program	Any adolescent children 13–18 of Consumer Parents	PATS Vic Pilot Program Evaluation 2002–2005; Hargreaves et al CAH 2005	• MWAMHS 8/52 After School Program since 2010 Brimbank	NO	YES	• Interagency Collaboration required • External

*Initial Engagement/Needs Assessment Focus preceding 'Targeted interventions'

Recommended Carer Support Options

An extensive detailed list of Carer Support Options currently offered internally by each AMHS and those offered by key 'External Agencies' are presented within tables in Appendix 12.2.

7.3 Consumer peer support

Consumer Peer Support Workers (PSWs) are people with a lived experience of mental health services who have appropriate knowledge and skills and are employed to provide direct care, support, and recovery-based education for consumers. There is growing evidence that PSWs benefit consumers' mental health and holistic health and wellbeing.

Consumer PSWs are grounded in a sense of empathy and mutuality with consumers, drawing on the experiences, knowledge, and personal reflection upon their own recovery journeys. The work of peer support may include goal setting, community connections and individual mentoring. Group work should be based on an inclusive leadership and open facilitation style, aimed at drawing out the knowledge of the group. PSW can encourage consumers to rekindle their hopes and strengthen their progress to personal recovery. The phased introduction of employed Consumer PSWs in NWMH reflects the views of the consumer movement that peer support is an under-used resource. The consequence of this for consumer advocacy is that it would make a difference to encourage, strengthen and resource peer support as a legitimate and systematic component of the services available for mental health consumers.

A major strength of peer support is that consumers can join in and share in lessons from experience and the healing benefits of human relationships, which could strengthen their journey of personal recovery.

Peer support allows consumers to participate regardless of their clinical diagnosis or state of illness. Some desirable elements of peer support include:

- sharing of personal experience about 'what helps' in the journey of recovery
- rekindling hopes, while building practical structures towards personal achievement
- encouraging a stronger sense of community
- sharing coping strategies for dealing with symptoms, illness, and ongoing life issues
- sharing information about community facilities and groups which affirm the value of the person
- understanding 'lessons from life' and the wisdom that can come from difficulties
- providing the opportunity to speak and be listened to with empathy and understanding.
- Mentoring, mutuality and shared learning

"Putting the community into Community Care Unit" demonstrates peer support methods that could make a major contribution to recovery-based approaches, shared learning experiences and increased participation in the wider community

7.4 Medication in practice

The majority of people attending NWMH will be prescribed medications, which are often very effective treatments and form part of the recovery plan. A key principle of adherence to medication is an acceptance that every individual's commitment to treatment is different, and that the commitment may fluctuate during periods of relapse or other stressful events. The therapeutic relationship can assist the individual and the clinician to work through any issues about medication and consider the strategies best suited to meeting the individual's needs.

In a recovery-oriented mental health service, a full range of psychotropic medication is available to support personal recovery. However, treatment with medication needs to be balanced with feedback from individuals and family/ carers. Medication – providing both positive benefits as well as the risks of side effects – is one of many strategies to support recovery.

These guidelines apply to all clinicians who prescribe, dispense or review medicines or who have a role in making decisions about medicines with individuals and families/carers.

Communication and information

Good communication is essential to support decisions about medicines and to support adherence:

- Clinicians should adapt their consultation style to the needs of the individual, emphasising the value of the person taking some responsibility for their own wellbeing.
- Consider different formats for providing information to ensure it is accessible and understandable, for example using pictures, symbols, large print, different languages, an interpreter or a carer/advocate.
- Encourage individuals to ask about their condition and treatment and use your expertise to help the person decide the best choice for them.

Increasing consumer involvement

Good 'medication in practice' outcomes are not just about giving the medication, but about giving the individual and family/carers information to make an informed choice, listening, talking to them about their experiences with medication and acting on what they say.

Discuss with the individual why they might benefit from the treatment. Clearly explain the disease or condition and how the medicine will influence it. Consider presenting medication as an 'exchangeable protection against relapse', in which pharmacological and psychosocial approaches both buffer the individual against relapse

Talk to the individual to explore their preferences, and support people who are uncertain about taking medication through crystallising their questions, focussing discussion on the contribution of medication to recovery goals, and providing unbiased information, including information about possible side-effects.

Encourage and support individuals and carers to keep an up-to-date list of all medicines being taken, including the names and doses of prescription and non-prescription medicines and herbal and nutritional supplements. Also note any medication allergies or adverse reactions.

Understanding the consumer's knowledge, beliefs and concerns about medicines

People make decisions about medicines based on their understanding of their condition and the possible treatments, their view of their own need for the medicine, and their concerns about the medicine. Individuals may wish to discuss what will happen if they do not take the recommended medicine, and how to reduce or stop medicines they may have been taking for some time, particularly those known to be associated with side effects.

Supporting adherence

Individuals often do not take their medicines exactly as prescribed. Adherence needs to be assessed regularly to allow an accurate judgment of the medicine's benefits, and also to explore whether the person needs more information and support. Recognise that non-adherence is common and that most people are sometimes non-adherent. Routinely assess adherence in a non-judgemental way whenever medicines are prescribed, dispensed or reviewed.

Adherence can be supported by information and discussion, or changes to the type of medicine or the regimen. Any interventions should be considered on a case-by-case basis and should address the concerns and needs of the individual. If someone is not taking their medicines, discuss the reasons: they may range from their beliefs, concerns or problems with the medicine (intentional non-adherence) to practical problems such as forgetting or not being organised (unintentional non-adherence).

Work constructively with people who want to come off medication, for example by discussing the advantages, disadvantages, risks, alternatives (for example continuing with medication for a fixed period and then reviewing the situation, identifying early warning signs and making a crisis plan before stopping, graded withdrawal, etc), validating their decision even where it differs from the prescriber's view, and identifying other supports and interventions which can lessen the need for medication.

Reviewing medicines

Some individuals benefit from long-term use of medicine. The initial decision to prescribe the medicine, the individual's experience of using it, and adherence should be reviewed regularly. Re-assess the person's knowledge, understanding and concerns about medicines (and that of the family/carers) at agreed intervals. Offer information repeatedly, especially when using multiple medicines in the treatment of long-term conditions.

Review the doses regularly, aiming to achieve the lowest effective dose. Doses are sometimes increased when a condition worsens, but not reduced when it improves or when the dose increase has proven ineffective. Some conditions require lower doses in the maintenance phase than in the acute phase.

Regularly monitor for the development of side-effects.

7.5 Intensive service support

An assertive outreach or intensive service delivery approach is only a vehicle for the delivery of treatment of adequate content and quality (Rosen, Mueser et al., 2007). Its success is likely to depend on the extent to which clinicians are equipped to provide rehabilitation and evidence-based psychosocial interventions. Burns & Firn (2002) have published a helpful and detailed manual for practitioners.

According to the Framework for Care document, intensive service delivery aims to 'work collaboratively with consumers and their family/carers providing assertive outreach, targeted treatment and rehabilitation in their own environment to meet their needs and preferences'. The 'assertive outreach' (or Assertive Community Treatment, ACT) approach to service delivery (Stein and Test, 1980) provides flexible, intensive, home-based treatment to people with severe mental health problems who have recently been high users of inpatient care. Intensive service delivery is recommended in clinical practice guidelines (Marshall and Lockwood, 1998; Dieterich, Irving et al., 2011).

Intensive service delivery is best reserved for consumers who were high users of hospital care over the previous 12 months (Burns, Catty et al., 2007), for example about 4 days per month in the past 2 years[1]. (Dieterich, Irving et al., 2011). Between 1 in 5 and 1 in 10 people with severe mental illnesses are likely to reach this threshold. Other characteristics of this subgroup include poor engagement with mental health services, for example being unable or unwilling to attend community mental health centres for treatment, not taking medication consistently and reliably, having symptoms that are resistant to treatment, experiencing frequent crises, being isolated because of limited social networks, and requiring assistance with daily living tasks (Harvey, 2012).

Consumers receiving intensive services engage better with services, are less likely to be admitted to hospital, spend less time as an inpatient when they are admitted, and have improved social functioning.

Components

Intensive service delivery works best when it closely resembles the original ACT model (Dieterich, Irving et al., 2011; Killaspy & Rosen, 2011). There is no evidence for effectiveness of 'diluted' models (Killaspy & Rosen, 2011). Seven specific components associated with greater effectiveness in reducing the use of inpatient care have been identified (Burns et al, 2007):

- being based in a community setting
- operating an extended hours service (7 days per week and out of office hours)
- the team manager having clinical as well as managerial responsibilities
- the team having full clinical responsibility for their patients (this includes inpatient units)
- holding daily team meetings to agree work priorities for the day
- a team-based approach or adopting a 'shared caseload' whereby all staff work flexibly with the team's patients, rather than using an individual case management approach
- offering a 'time unlimited' service that avoids discharging patients from the service because of 'disengagement'.

Other critical components include:

- integrated management of health and social care staff (essentially direct services provided by staff which address the consumer's social as well as health care needs)
- the degree to which staff contact clients outside of health care settings (for example at home or elsewhere in the community, recommended as at least 80% of all contacts).

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[1] It is important to note that any definition of 'high inpatient usage' will depend on overall bed numbers and availability and therefore threshold for admission

Team-based approach
The team-based approach is the least understood feature of intensive service delivery. It involves clinicians meeting together daily to plan and share responsibilities. This process also enables frequent discussion of ideas about how to engage and work effectively with consumers as well as supportive and constructive containment for staff in working with challenging situations (Killaspy, Johnson et al., 2009; Harvey, Killaspy et al., 2011).

The team-based approach provides better continuity of care and minimises the adverse impact of absences and changes in key worker, as the consumer relates to all members of the team rather than just their own case manager (Burns & Firn, 2002). However, there is now increasing consensus that there is an optimal number of clinicians that should be involved with each consumer, between two and about ten, for several reasons. First, consumers who may be hard for services to engage often have profound difficulties in establishing a relationship of trust. It takes time, commitment and consistency to do it. Frequently it is best to start with building up one relationship and then, gradually, extends the network. Secondly, a purely task-centred approach is inefficient as it takes too much time and energy to administer and supervise, including a large amount of time required to impart and share information and check that everything has been done. Finally, most consumers want a recognisable individual who brings awareness of their needs and continuity to their ongoing recovery. Thus, most intensive service delivery approaches have evolved to provide a primary and secondary case manager with back-up from some or all of the rest of the team as required (Burns & Firn, 2002).

Engagement
Engaging with previously marginalised consumers is a critical skill for clinicians offering intensive service delivery. More collaborative, informal, flexible and responsive approaches are required; include provision of help with practical issues and informal support to families Angell and Mahoney, 2007; Krupa, Eastabrook et al., 2005; Killaspy, Johnson et al., 2009). Key elements of engagement include persistence by clinicians, the trust that consumers developed in their clinicians, and the process by which their clinicians became 'guides' to the world of psychiatric and social services to facilitate community adjustment. A useful synthesis of guidelines for best practice in early engagement derived from the literature, research in assertive outreach teams (3 of 4 in NWMH) and local practice wisdom can be found at: BPGEE resource on intranet (coming soon).

It is It is difficult to provide definitive answers about how this function should be provided in the absence of evidence from trials of 'integrated' or 'diluted' models. However, it would seem sensible to try and replicate as many of the critical components as possible (nine in total) summarised above, to provide this service preferentially to consumers with high inpatient usage and the other characteristics described earlier, to organise individual clinician and team working to optimise and sustain therapeutic engagement, and to ensure that this subgroup of consumers are provided evidence-based medical and psychosocial treatments wherever possible.

7.6 The deteriorating person, person in crisis and suicidal behaviour

This section outlines how to deal with situations that require urgent assessment and response. Requests for urgent assessments will be made for new individuals through Centralised Triage or from within the general hospital. Individual's currently with the area mental health service may also require an urgent assessment.

Crisis
There is no simple definition of a crisis. A crisis may include:

- an individuals', or family/carer's, perception or experience of a situation as intolerable and exceeding current resources and coping mechanisms
- a high level of concern about potential adverse events
- disruptive or disorganised behaviour that cannot be managed in the current setting.

A crisis requires a response, and the urgency of the response will depend on the type of crisis. When the required response is not determined to be immediate or urgent, then work is still required to address the *perceived* crisis. The crisis may also be within the family or support system.

A crisis is often a time when individuals feel they have run out of ideas or solutions, and it can represent an opportunity to apply strategies developed in the recovery plan. Individuals can be supported to act early, to consider a range of options, to access additional supports and to identify strengths in themselves and their systems. A crisis may be an important experience in developing confidence and skills as part of personal recovery.

Triage

When dealing with any request for psychiatric help a judgment is made as to:

- whether a mental health response is appropriate
- the urgency of an initial assessment
- the venue for that assessment.

It is necessary to determine the appropriate time between receiving the request and the first assessment. Before concluding the call, the triage clinician must ensure that the caller understands the plan.

For new clients to the service (outside the general hospital) the triage function is performed by After Hours Centralised Triage. In the general hospital the triage function is performed by the ECAT or consultation-liaison services. For current consumers of the service, these functions are performed by the key worker or their delegate.

Centralised triage has developed guidelines for the determining the type, timeliness and venue of response, including the statewide triage dispositions.

Statewide dispositions that require urgent response are:

- **Triage disposition A:** An emergency response – ambulance, emergency department or police.
- **Triage disposition B:** Very urgent mental health response within 2 hours – outreach or urgent clinic appointment provided by Community Mental Health Team (CMHT). Directed to emergency department if timely response cannot be provided.
- **Triage disposition C:** Urgent mental health response within 8 hours - referral to CMHT for face-to-face assessment.

For further information on triage see http://www.health.vic.gov.au/mentalhealth/pmc/triage.htm and Appendix 12.3: Triage Scales.

Providing an urgent response

Immediate actions

Using the information provided from the referral, recommendations about management might be needed before the face-to-face assessment, including:

- other services required (Police, Ambulance, Child Protection)
- setting and timeliness for psychiatric assessment
- safety of the individual, children, family/carer and referring service personnel
- levels of observation
- actions required in response to specific behaviours
- transportation.

Face to face assessment

Setting: The assessment is conducted at a venue which has adequate privacy, safety and accessibility.

Format: The assessment is conducted in keeping with the guidelines for assessment (see Section 3). The assessment will conclude with a summary and formulation of the current difficulties and a psychiatric diagnosis. Guidelines have been developed for some common acute and crisis presentations.

Priorities: For working with the suicidal person see Working with the suicidal person: Clinical guidelines for emergency departments and mental health services(2010)

Priorities in the acute assessment include:

- accessing collateral history from family/carers and identified significant others
- excluding physical causes for mental state abnormalities and detecting co morbid medical illness
- assessing safety and level of risk.

It is important to determine if there are current management, family/dependant care plans or advance statements that should be considered before to commencing the assessment.

Immediate management and actions

A priority and urgency is determined for each problem. Management is decided with reference to the needs and wishes of the person and the family/carers, the recommendations of practitioners involved in their care, and pre-existing management, family/dependant care plans and advanced statements. A focus on communication with the person, family/carers and other services/units is a priority.

For problems requiring an immediate response, actions may include:

- pharmacological and non-pharmacological treatment
- support of the person, providing a sense of hope and a sense of direction as well as a plan to assist them and their family/carers
- further investigations as needed
- determining the level of observation, containment and the venue required.
- action under the Mental Health Act.
- use of the Children, Youth and Families Act and NWMH ECEC procedures
- defining the timing of a subsequent review
- recommending actions in response to specific behaviours.

Ongoing actions and support

In the case of a new client, continuity of care should be maintained between the client and the clinician conducting the initial assessment. Where this is not practical, any disruption of care can be reduced by:

- identifying and introducing the clinician who will provide ongoing care
- limiting the clinicians involved to a key clinician, and identifying the key clinician.
- In the case of a known client, continuity of care can be maintained by the key clinician conducting the urgent assessment wherever possible. If this cannot be achieved, coordination of the case is returned to the key clinician as soon as practical.

End of episode of acute care

An acute episode can end when the problems that required an urgent response are resolved. At this time the person may continue to be a client of the service in order to pursue other recovery goals, or be transferred to primary care services.

Risk assessment and management

Risk assessment is an important but controversial issue. It is important because people with mental health problems are at increased risk of experiencing a range of adverse events, including suicide, self-harm, aggression, physical illness, neglect, abuse and exploitation. Accurate assessment of risk is essential for effective management of the risk, providing an opportunity for it to be negated or reduced. Risk assessment and management is therefore an essential component of safe clinical practice.

There are a number of limitations in risk assessment. Risk cannot be eliminated, as some degree of risk is present in everything we do. In addition, risk is dynamic and changeable. Risk factors for adverse outcomes such as suicide are derived from population-level data, so they do not necessarily provide reliable guidance for decision-making at an individual level where the context and individual assessment are more important. For example, it is well known that people presenting after a suicide attempt or in crisis have a greatly increased risk of suicide, but fewer than 1 in 200 will complete suicide in the next 6 months. No single factor, or combination of factors, is able to accurately predict those individuals who will commit suicide, even amongst high-risk groups (Ryan C, Large M. *Medical Journal of Australia* 2013; 198: 462-463). Over-reliance on 'risk assessment' is likely to be ineffective. Instead, risk assessment should always be part of a comprehensive clinical assessment, and should lead to a rational management plan.

There are also concerns that complete avoidance of risk is not consistent with the principles of recovery, as taking risks is necessary for people to grow, develop and change. Michael Slade suggests that a solution to this dilemma is to distinguish between 'positive' risks needed for growth, and harmful risk-taking such as suicidal and homicidal acts, antisocial and criminal behaviour, personal irresponsibility, self-harming behaviours and relapse of mental illness, which should be avoided (Slade, M. 2009).

There are some practical steps which can help clinicians resolve these issues:

- Distinguish between positive and harmful risks. Work constructively with consumers using a recovery approach which includes positive risk-taking where appropriate.
- In regard to harmful risk, use the NWMH Community Risk Screening Tool at entry into and exit from the service, at times of crisis or increased risk, and at other times such as clinical reviews, in conjunction with comprehensive clinical assessment.
- Collateral information from families/carers is often very useful in assessing risk and should always be obtained if possible.
- Ensure that the risk management section is completed, and further detail of the plan is written in the progress notes.
- Review the dynamic risk factors at appropriate intervals.
- When working with people at high risk, remember to focus on resilience, strengths and hope for recovery.
- Discuss the plan with senior clinicians or team leaders

Resources:

- NWMH Community Risk Screening Tool
- Working with the suicidal person: A summary guide for emergency departments and mental health services. Mental Health, Drugs and Regions branch, Victorian Government Department of Health, 2010 www.health.vic.gov.au/mental health/suicide

NorthWestern Mental Health is committed to providing safe and effective health care but recognises that in any complex health care system sometimes things go wrong. Equipment can fail, systems may prove inadequate and occasionally errors of judgment are made. In relatively few cases there is serious harm to the individual.

Review strategies adapted from high risk industries have been applied to the management of health care delivery. This approach relies on gathering information on any incident that might affect safety, analysing the factors that contributed to the incident and making changes to the way things are done. Such an approach recognises that the vast majority of errors are due to flaws in a chain of events, not the actions of an individual.

The NWMH Clinical Risk Management Bulletins support clinicians to focus attention on learning. It also helps to clearly articulate the expected standards of care across the organisations.

Advanced Suicide Assessment and Planning (ASAP)
NWMH have adopted the *Framework for Advanced Suicide Assessment and Planning which are relevant* to all health settings. It provides detailed information on conducting suicide risk assessments and specific information on the roles and responsibilities of generalist and mental health services to guide the suicide risk assessment and management process.

Click here for information on ASAP.

7.7 Physical health (content under development)

Physical health needs can be diverse, ranging from pregnancy and breast screening to cardiovascular risk and the metabolic syndrome.

Metabolic monitoring
Metabolic monitoring aims to improve the detection and treatment of cardiovascular risk factors in people with mental illness. People with severe and chronic mental illnesses such as schizophrenia have a substantially reduced life expectancy compared to the general population, largely because of a cardiovascular disease. Cardiovascular mortality in people with chronic mental illness has not shown the same improvement that has occurred in the general population since the 1970s – in fact, a 'widening of the mortality gap' has been described. The disparity in cardiovascular risk factors was illustrated the 2010 Australian National Survey of People Living with Psychotic Illness', which showed:

- two-thirds of people smoked tobacco compared to about one-fifth of the general population
- 45% were obese, compared to about 25% in the general population, and more than 80% of those met the criteria for high-risk abdominal obesity
- one in 5 had diabetes compared to about 1 in 20 of the general population
- half had an unhealthy lipid profile, elevated blood pressure, or both
- risk factors were often undetected and untreated
- about one-third were at medium or high risk of having a cardiovascular event in the next five years, even though about 90% were under 55 years of age.

Metabolic monitoring refers to the regular screening for cardiovascular risk factors including diabetes or glucose intolerance, dyslipidaemia (for example, high cholesterol), hypertension (high blood pressure), obesity, smoking status and exercise levels. This includes tracking the potential metabolic disturbances associated with antipsychotics and other medications.

NWMH has developed a number of resources to assist with regular monitoring of cardiovascular risk factors including:

- Equipment: All services should have scales, height measures, tape measures, blood pressure cuffs etc. Services are encouraged to have regular checks and audits of equipment.
- NWMH Metabolic Monitoring form: The Metabolic Monitoring form should be included in every medical record in paper-based systems, or the Client Patient Folder in electronic systems. Side 1 of the form records results and tracks changes in cardiovascular risk factors ('metabolic monitoring'). Side 2 records and tracks other blood results and investigations related to psychiatric medications.
- NWMH Metabolic Monitoring Algorithm (Appendix 12.4): The algorithm includes information about five cardiovascular risk factors: body mass index (BMI) and waist circumference, blood pressure, blood glucose levels, lipid profile and smoking status. It provides guidelines about how frequently monitoring should occur in different scenarios – for example when 12-monthly monitoring might be adequate and when 3-monthly checks are recommended. It also provides information about normal and abnormal results and when referral to GPs or specialists should be considered.
- Metabolic monitoring video: Available on the NWMH intranet, the video introduces to the issue of metabolic monitoring for new staff.

In summary:

- Metabolic monitoring and consideration of other physical health issues should be a part of every person's treatment plan.
- Metabolic monitoring should occur at least once a year and more frequently for people at higher risk of cardiovascular disease (see algorithm)
- Collaboration with GPs is an essential part of physical health care. However it is the clinician's responsibility to ensure that GP follow-up and intervention occurs and, if not, to make alternative arrangements to address any metabolic issues.
- Every appointment is an opportunity to consider issues of physical health, to address ongoing risk factors such as smoking, inactivity and poor diet, and to consider how to improve a person's wellbeing.
- Additional resources can be found on the the NWMH intranet and or ipolicy.

8. Treatments and programs applicable to specific disorders

This section includes the more common disorders managed by our community teams and is not a comprehensive list of the disorders presenting within our services. It focuses on treatment and/or programs recommended by the latest clinical practice guidelines. This section should be read in conjunction with Section 6.1 outlining the decision-making process for choosing treatments, and Section 7 outlining universal interventions and services applicable across disorders.

8.1 Schizophrenia

The Table below summarises the existing evidence on psychosocial treatments for schizophrenia.

Psychosocial Treatments for Schizophrenia	**NICE (2010)** [1]	**PORT (2009)** [2]	**APA (2004)** [3]	**Canadian (2005)** [4]	**RANZCP (2005)** [5]	**Nathan (2007)** [6]	**Roth (2005)** [7]
(Behavioural) Family Interventions/ Family Psychoeducation	Y	Y	Y	Y	Y	Y	Y
Cognitive Behavioural Therapy	Y	Y	Y		Y	Y	Y
Social Skills Training	X	Y	Y	Y	Y	Y	?
Assertive Community Treatment		Y	Y		Y	Y	
Individual Psychoeducation	?				Y	Y	Y
Supported Employment (Individual Placement &Support)		Y	Y			Y	
Vocational Rehabilitation				Y	Y	Y	
Integrated Substance Use and Mental Health Tx	?		Y	Y			
Motivational enhancement for substance use		Y					
Art Therapies	Y						
Behaviour Modification						Y	
Cognitive remediation	X	?				Y	?
Medication Adherence therapy	X	X	Y	?	?		?
Counselling & supportive therapies	X?						
Psychodynamic therapies	X				X		X

Legend:
Y = recommended
X = not enough evidence
? = some evidence, not enough to recommend
blank = not considered

🟩 Recommended by Clinical Practice Guideline
🟦 Recommended by other recognised authorities

Sources:

1. National Institute of Clinical Excellence (2010). Core interventions in the treatment and management of Schizophrenia in adults in primary and secondary care (Updated edition). London: The British Psychological Society & The Royal College of Psychiatrists
2. Kreyenbuhl J, Buchanan R W, Dickerson F B et al. The Schizophrenia Patient Outcomes Research Team (PORT): updated treatment recommendations 2009. *Schizophrenia Bulletin* 2010; 36: 94-103.
3. Lehman AF, Lieberman JA, Dixon LB et al. Practice guideline for the treatment of patients with schizophrenia, second edition. *American Journal of Psychiatry* 2004; 161 (Supplement 2): 1.
4. Canadian Psychiatric Association. Clinical Practice Guidelines. Treatment of Schizophrenia. *Canadian Journal of Psychiatry* 2005; 50 (Supplement 1): 7S-56S.
5. RANZCP Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry* 2005; 39: 1-30.
6. Nathan PE, Gorman JM. *A guide to treatments that work.* New York: Oxford University Press, 2007.
7. Roth A, Fonagy P. What works for whom? A critical review of psychotherapy research. New York: Guilford Press, 2005.

PORT recommendations

The following recommendations on psychosocial treatments for schizophrenia were published by the Patient Outcomes Research Team (PORT) in 2009.

Assertive community treatment

This intervention should be provided for people who are at risk of repeated hospitalisations or were recently homeless. The key elements include a multidisciplinary team that provides a medication prescriber, a shared caseload among team members, direct service provision by team members, a high frequency of patient contact, low patient to staff ratios, and outreach to patients in the community.

Supported employment

Any person with schizophrenia who has the goal of employment should be offered supported employment to assist them in obtaining and maintaining competitive employment. The key elements include individually tailored job development, rapid job search, the availability of ongoing job supports, and the integration of vocational and mental health services.

Skills training

People with schizophrenia who have deficits in skills that are needed for everyday activities should be offered skills training in order to improve social interactions, independent living, and other outcomes that have clear relevance to community functioning. Skills training programs vary widely in content but typically include a focus on interpersonal skills and shared elements such as behaviourally-based instruction, role modelling, rehearsal, corrective feedback, and positive reinforcement. Skills training provided in clinic-based settings should be supplemented with strategies for ensuring adequate practice in applying skills in an individual's day-to-day environment.

Cognitive behavioural therapy

People with schizophrenia who have persistent psychotic symptoms while receiving adequate pharmacotherapy should be offered adjunctive cognitive-behaviourally oriented psychotherapy to reduce the severity of symptoms. The therapy may be provided in either a group or an individual format and should be approximately 4–9 months in duration. The key elements include the collaborative identification of target problems or symptoms and the development of specific cognitive and behavioural strategies to cope with these problems or symptoms.

Family-based services

People with schizophrenia who have ongoing contact with their families and significant others should be offered a family intervention that lasts at least 6–9 months. Key elements of effective family interventions include illness education, crisis intervention, emotional support, and training in how to cope with illness symptoms and related problems. The selection of a family intervention should be guided by collaborative decision-making by the patient, family and clinician. A family intervention of at least 4 sessions should be offered if a longer intervention is not feasible or acceptable, focussing on education, training, and support.

Psychosocial interventions for alcohol and substance use disorders

People with schizophrenia and a comorbid alcohol or drug use disorder should be offered substance abuse treatment. The key elements include motivational enhancement and behavioural strategies that focus on engagement in treatment, coping skills training, relapse prevention training, and its delivery in a service model that is integrated with mental health care. Brief (1-6 sessions) and more extended (10 or more sessions) interventions are helpful in reducing substance use and improving psychiatric symptoms and functioning.

Psychosocial interventions for weight management

People with schizophrenia who are overweight (BMI 25.0–29.9) or obese (BMI 30 or more) should be offered a psychosocial weight loss intervention that is at least 3 months in duration to promote weight loss. Key elements include psychoeducation focused on nutritional counselling, caloric expenditure and portion control; behavioural self-management including motivational enhancement; goal setting; regular weigh-ins; self-monitoring of daily food and activity levels; and dietary and physical activity modifications.

For full version of the guidelines click here.

NICE recommendations

The following recommendations on psychosocial treatment in schizophrenia are from UK National Institute for Health and Care Excellence (NICE), 2009.

Treating the acute episode

- Offer cognitive behavioural therapy (CBT) to all people with schizophrenia.
- Offer family intervention to families of people with schizophrenia living with or in close contact with the service user.
- Consider offering arts therapies, particularly to help negative symptoms of schizophrenia.
- Start CBT, family intervention or arts therapies either during the acute phase or later, including in inpatient settings.
- Do *not* routinely offer counselling, supportive psychotherapy or social skills training as specific interventions. However, consider the individual's preferences for counselling and supportive psychotherapy, especially if CBT, family intervention and arts therapies are not available locally.
- Do not offer medication adherence therapy as a specific intervention.

Promoting recovery (community and inpatient)

- Assertive outreach teams (assertive community treatment) should be provided for people with schizophrenia who frequently use inpatient services, and have a history of poor engagement with services leading to frequent relapse or social breakdown (homelessness or inadequate accommodation).
- Offer CBT (as described above) to service users with persisting positive and negative symptoms or those in remission.
- Offer family intervention (as described above) to families living with or in close contact with the service user. Family intervention may be useful for families of people who have recently relapsed, are at risk of relapse or have persisting symptoms.
- Consider offering arts therapies, particularly to people with negative symptoms (as described above).
- For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:
  - review the diagnosis
  - establish that there has been adherence to antipsychotic medication, prescribed at an adequate dose and for the correct duration
  - review engagement with and use of psychological treatments and ensure that these have been offered; if family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families
- consider other causes of non-response, such as comorbid substance misuse (including alcohol), the concurrent use of other prescribed medication or physical illness.

Employment, education and occupational activities

- Provide supported employment programs for those who want to return to work or find a job. Programs should not be the only work-related activity offered when people are unable to work or cannot find a job.
- Mental health services should work with local stakeholders, including those representing minority groups, to enable access to local employment and educational opportunities. This support should take into account the person's needs and skill level.

Delivering psychological interventions

Cognitive behavioural therapy:

- Deliver CBT on a one-to-one basis over at least 16 planned sessions. Follow a treatment manual so that people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning, and so that a re-evaluation of perceptions, beliefs or reasoning relates to the target symptoms.
- CBT should include at least one of the following components:
  - monitoring thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
  - promoting alternative ways of coping with the target symptom
  - reducing distress
  - improving functioning.

Family intervention should:

- include the service user if practical
- include at least 10 planned sessions over a period of 3 months to 1 year
- take into account any preference for single-family intervention rather than multi-family group intervention
- take into account the relationship between the main carer and the service user
- have a specific supportive, educational or treatment function
- include negotiated problem solving or crisis management work.

Arts therapies should:

- be provided by trained therapists with experience of working with people with schizophrenia
- be offered in a group format unless there are issues of acceptability, access or engagement
- combine psychotherapeutic techniques with activities aimed at promoting creative expression, which are often unstructured and led by the service user
- help people to experience themselves differently and develop new ways of relating to others; express themselves and organise their experience into a satisfying aesthetic form; and accept and understand feelings that may have emerged during the creative process (including for some, how they came to have these feelings) at their own pace.

Role of psychoanalytic and psychodynamic approaches

Healthcare professionals may consider psychoanalytic and psychodynamic principles to help them understand the service user's experiences and their interpersonal relationships.

[See: NICE (2009). *Core interventions in the treatment and management of schizophrenia (update).* Clinical Guideline CG82. National Collaborating Centre for Mental Health, UK. http://guidance.nice.org.uk/CG82/

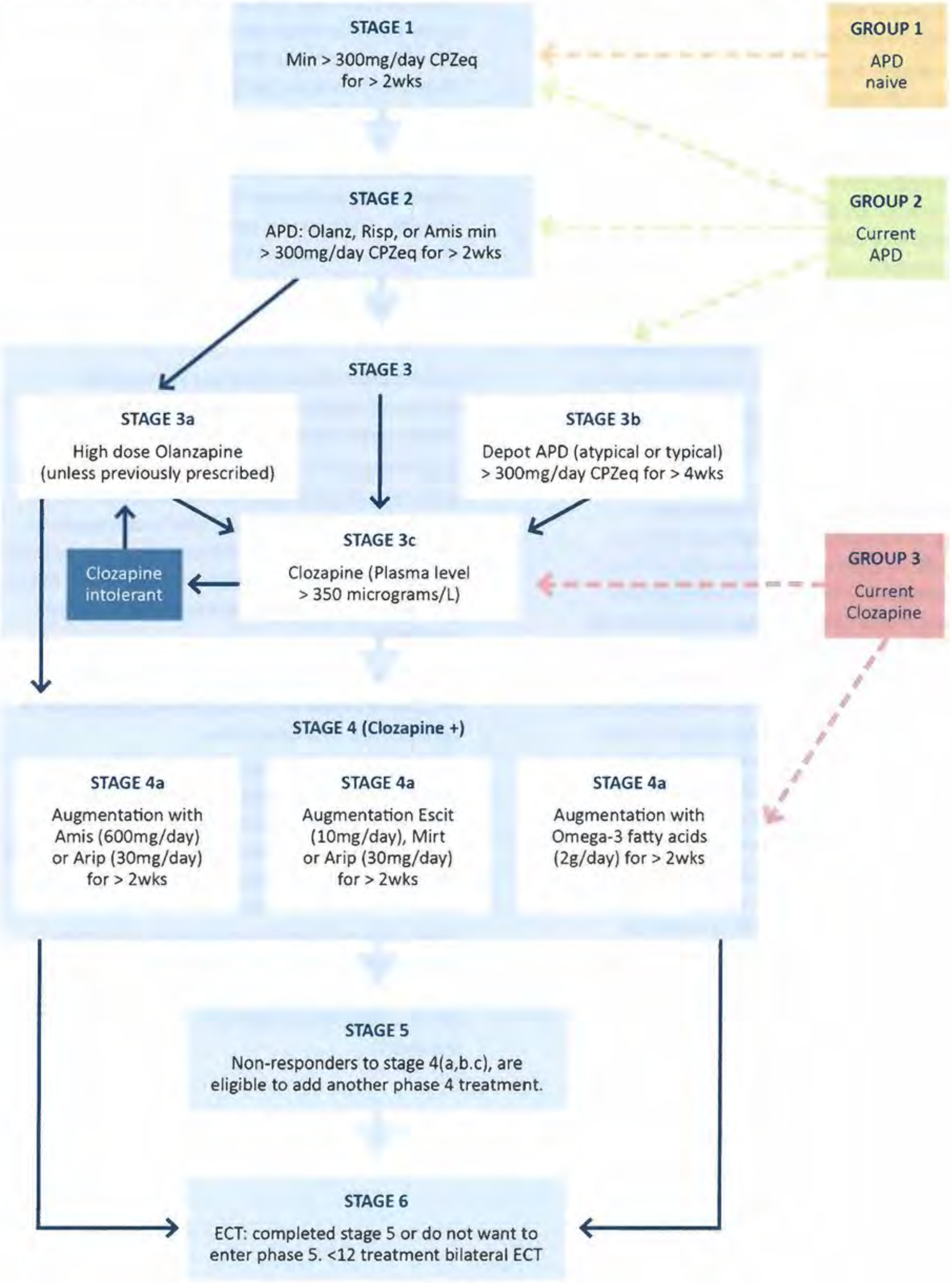
Psychosis with coexisting substance misuse

The NICE guideline outlines the pathways to coordinated care, as summarised below, rather than detailing specific psychosocial interventions for substance use by people living with psychotic disorders. Specific treatments for psychosis and for substance use that are referred to in specific guidelines for these disorders should be considered.

- Do not exclude adults and young people with psychosis and coexisting substance misuse from age-appropriate mental health care either because of their substance misuse or because of a diagnosis of psychosis.
- In most cases, treatment for both conditions should be provided by healthcare professionals in secondary mental health services such as community-based mental health teams.
- Consider seeking specialist advice and initiating joint working arrangements with specialist substance misuse services for adults and young people with psychosis being treated by community mental health teams, and known to be severely dependent on alcohol, dependent on both alcohol and benzodiazepines, or dependent on opioids, cocaine or crack cocaine.
- Adult community mental health services or CAMHS should continue to provide care coordination and treatment for the psychosis within joint working arrangements.
- Consider seeking specialist advice and initiate joint working arrangements with specialist substance misuse services if the person's substance misuse is difficult to control and/or leads to significant impairment of functioning, family breakdown or significant social disruption such as homelessness

[See: NICE (2011) Psychosis with coexisting substance misuse. Assessment and management in adults and young people. NICE clinical guideline 120. Developed by the National Collaborating Centre for Mental Health http://www.nice.org.uk/guidance/CG120
For full version of the guidelines please click on the following link: http://guidance.nice.org.uk/CG82/]

Figure 1: The treatment algorithm to be compared against treatment as usual. CPZeq – chlorpromazine equivalents; Olanz – olanzapine; Risp – risperidone; Amis – amisulpride; Arip – aripiprazole; Escit – escitalopram; Mirt – mirtazapine; ECT- Electroconvulsive therapy



Sundram, S (n.d.) unpublished communications.

Pharmacological treatments and interventions

This evidence is based mainly on the Schizophrenia PORT treatment recommendations (2009 Schizophrenia Patient Outcomes Research).

- Treatment of acute positive symptoms in treatment-responsive people with schizophrenia: acute antipsychotic treatment medication

  Recommendation: In people with treatment-responsive, multi-episode schizophrenia who are experiencing an acute exacerbation of their illness, antipsychotic medications, other than clozapine, should be used as the first line of treatment to reduce positive psychotic symptoms. The initial choice of antipsychotic medication or the decision to switch to a new antipsychotic should be made on the basis of individual preference, prior treatment response, and side effect experience; adherence history; relevant medical history and risk factors; individual medication side effect profile; and long-term treatment planning.

- Treatment of acute positive symptoms in treatment-responsive people with schizophrenia: acute antipsychotic medication dose

  Recommendation: In people with treatment-responsive, multi-episode schizophrenia who are experiencing an acute exacerbation of their illness, the daily dosage of first-generation antipsychotic medications should be in the range of 300-1000 mg chlorpromazine (CPZ) equivalents. The daily dosage of second-generation antipsychotic medications for an acute symptom episode should be: aripiprazole 10-30 mg*; olanzapine 10-20 mg*; paliperidone 3-15 mg; quetiapine 300-750 mg*; risperidone 2-8 mg; amisulpride 400-800 mg; ziprasidone 80-160 mg*; amisulpride 400-800 mg; asenapine 10-20 mg (*insufficient evidence to determine the upper effective dose limit; quoted upper dose is the approved upper dose). Dose should be kept to the minimum effective dose. Side effects should be carefully monitored and dose adjusted accordingly. Treatment trials should be at least 2 weeks, with an upper limit of 6 weeks to observe optimal response.

- Treatment of acute positive symptoms in people with first-episode schizophrenia: antipsychotic medication choice

  Recommendation: Antipsychotic medications, other than clozapine and olanzapine, are recommended as first-line treatment for people with schizophrenia experiencing their first acute positive symptom episode.

- Treatment of acute positive symptoms in people with first-episode schizophrenia: antipsychotic medication dose

  Recommendation: People with first-episode schizophrenia exhibit increased treatment responsiveness and an increased sensitivity to adverse effects compared with people with multi-episode schizophrenia. Antipsychotic treatment should, therefore, be started with doses lower than those recommended for multi-episode patients (first-generation antipsychotics - 300-500 mg CPZ equivalents; risperidone and olanzapine - lower half of recommended dosage range for multi-episode patients). An important exception is quetiapine, which often requires titration to 500–600 mg/day. The therapeutic efficacy of low-dose aripiprazole or ziprasidone has not been evaluated in people with first-episode schizophrenia.

- Maintenance pharmacotherapy in treatment-responsive people with schizophrenia: maintenance antipsychotic medication treatment

  Recommendation: People with treatment-responsive, multi-episode schizophrenia who experience acute and sustained symptom relief with an antipsychotic medication should be offered continued antipsychotic treatment in order to maintain symptom relief and to reduce the risk of relapse or worsening of positive symptoms.

- Maintenance pharmacotherapy in treatment-responsive people with schizophrenia: maintenance antipsychotic medication dose

  Recommendation: In people with treatment-responsive, multi-episode schizophrenia who experience acute and sustained symptom relief with an antipsychotic medication, the maintenance dosage for first-generation antipsychotics should be in the range of 300-600 CPZ equivalents per day. The maintenance dosage for aripiprazole, olanzapine, paliperidone, quetiapine, risperidone and ziprasidone should be the dose found to be effective for reducing positive psychotic symptoms in the acute phase of treatment.

- Maintenance pharmacotherapy in treatment-responsive people with schizophrenia: long-acting antipsychotic medication maintenance treatment

  Recommendation: Long-acting injectable (LAI) antipsychotic medication should be offered as an alternative to oral antipsychotic medication for the maintenance treatment of schizophrenia when the LAI formulation is preferred to oral preparations. The recommended dosage ranges are fluphenazine decanoate 6.25-25 mg every 2 weeks; zuclopenthixol decanoate 50-400 mg every 2 weeks; flupenthixol decanoate 20-120 mg every 2 weeks; haloperidol decanoate 50-200 mg every 4 weeks. Alternative dosages and administration intervals equivalent to the recommended dosage ranges may also be used. The recommended dosage range for risperidone long-acting injection is 25-75 mg every 2 weeks, and for paliperidone long-acting injection 25-50 mg every 4 weeks.

- Maintenance pharmacotherapy in treatment-responsive people with schizophrenia: targeted, intermittent antipsychotic medication maintenance strategies

  Recommendation: Targeted, intermittent antipsychotic maintenance strategies should not be used routinely in lieu of continuous maintenance treatment regimens due to the increased risk of symptom worsening and relapse.

- Clozapine for positive symptoms in treatment-resistant schizophrenia

  Recommendation: Clozapine should be offered to people with schizophrenia who continue to experience persistent and clinically significant positive symptoms after 2 adequate trials of other antipsychotic agents. A trial of clozapine should last at least 8 weeks at a dosage from 300-800 mg/day.

- Monitoring clozapine blood levels

  Recommendation: If a person treated with clozapine has failed to demonstrate an adequate response, then a clozapine blood level should be obtained to ascertain whether the clozapine level is above 350 ng/ml. If the blood level is less than 350 ng/ml, then the dosage should be increased, to the extent that side effects are tolerated, to achieve a blood level above 350 ng/ml.

- Clozapine for hostility

  Recommendation: A trial of clozapine should be offered to people with schizophrenia who present with persistent symptoms of hostility and/or display persistent violent behaviours.

- Clozapine for suicidality

  Recommendation: A trial of clozapine should be considered for people with schizophrenia who exhibit marked and persistent suicidal thoughts or behaviours.

- Prophylactic anti-parkinsonian medications

  Recommendation: The therapeutic dose of a first-generation antipsychotic (FGA) should ideally be lower than the dose which causes extrapyramidal side effects, so prophylactic use of anti-parkinsonian agents to reduce the incidence of extrapyramidal side effects will not be necessary. Where extrapyramidal side effects do occur, the dose of medication and clinical response should be reviewed to determine whether to add an anti-parkinsonian agent, to reduce the dose, or to change to a different antipsychotic, including second-generation antipsychotic (SGA). Where an FGA is to be used due to lack of efficacy of an SGA, then an anti-parkinsonian agent should be introduced after the therapeutic dose is achieved.

- Medication to treat acute agitation in schizophrenia

  Recommendation: An oral or intramuscular (IM) antipsychotic medication, alone or in combination with a rapid-acting benzodiazepine, should be used in the pharmacological treatment of acute agitation in people with schizophrenia. If possible, the route of antipsychotic administration should correspond to the preference of the individual. (Also see NWMH Prescribing Guidelines for Management of Agitation.)

- Intervention for smoking cessation in schizophrenia

  Recommendation: People with schizophrenia who want to quit or reduce cigarette smoking should be offered treatment with bupropion SR 150 mg twice daily for 10-12 weeks, with or without nicotine replacement therapy, to achieve short-term abstinence. This pharmacological treatment should be accompanied by a smoking cessation education or support group, although the current evidence base is insufficient to recommend a particular psychosocial approach.

- ECT for the treatment of schizophrenia

  Recommendation: ECT may be an effective treatment for acute relapses of schizophrenia which are not responding to pharmacological treatment.

8.2 First episode psychosis

The following principles of management of the early stages of psychotic illness are derived from the work of EPPIC (Early Psychosis Prevention and Intervention Centre), which is part of Orygen Youth Health..

Detection and intervention for psychosis should be provided as early as possible in order to minimise the biopsychosocial impact of the illness for the individual and their family

- Interventions should be tailored to the phase of the psychotic illness and the age of the individual
- Optimal care consists of integrated biopsychosocial interventions individually tailored for each person and their family
- Care should be provided in the least restrictive setting and consist of empirically validated interventions

The aims of EPPIC (EPPIC clinical guidelines) are:

- Early identification and treatment of the primary symptoms of psychotic illness
- Improved access to and reduced delays in initial treatment
- Reducing frequency and severity of relapse, and increasing time to first relapse
- Reducing secondary morbidity in the post-psychotic phase of illness
- Reducing disruption to social and vocational functioning and psychosocial development in the critical period following onset of illness when most disability tends to accrue
- Promoting well-being among family members and reducing the burden for carers

The aims of treatment are:

- Explore the possible causes of psychotic symptoms and treat them (What is psychosis?)
- Educate the young person and their family about the illness (Phases of psychosis)
- Reduce disruption in a young person's life caused by the illness, restore the normal developmental trajectory and psychosocial functioning
- Support the young person and their carers through the recovery process
- Restore normal developmental trajectory and psychosocial functioning
- Reduce the young person's chances of having another psychotic experience

Further information about EPPIC and early psychosis, including The Australian clinical guidelines for early psychosis - A brief Summary for practitioners, and many other resources can be accessed by registering with the EPPIC website: www.eppic.org.au.

8.3 Bipolar affective disorder

The most helpful treatment guidelines for bipolar affective disorder are those published jointly by the Canadian Network for Mood and Anxiety Treatments (CANMAT) and the International Society for Bipolar Disorders. The guidelines from the UK National Institute for Health and Care Excellence (NICE) are also useful, providing additional detail on psychosocial interventions.

Psychosocial intervention recommendations from CANMAT

The CANMAT bipolar disorder recommendations are predominantly focused on medication treatments, but briefly consider psychosocial treatments that can be used in conjunction with recommended medication treatments.

No evidence-based psychosocial intervention has been identified for the acute management of bipolar mania and depression.

For maintenance therapy in bipolar disorder the priority intervention is psychoeducation, including systematic interventions (self-help or professionally delivered) that teach individuals to recognise and manage early warning symptoms. This strategy may delay the recurrence of mood episodes, reduce hospitalisation and improve functioning. Due to the relative ease of implementation, fewer sessions are typically required compared with formal therapies. The intervention is relatively low cost when implemented in a group format. The intervention should be an essential component of clinical management for all patients.

Other therapies supported by reasonable research-based evidence include:

- CBT and cognitive therapy specific to bipolar disorder (for example Basco and Rush; Lam)
- interpersonal and social rhythm therapy (Frank)
- family focussed therapy (Miklowicz) and similar behavioural family therapies
- group carer education.

Psychosocial intervention recommendations from NICE

- **Depressive symptoms**
  The NICE guidelines state that if there is no significant improvement after an adequate trial of drugs for moderate bipolar depression, a structured psychological therapy focused on depressive symptoms, problem solving, improving social functioning and medication concordance should be considered.
- **Acute episode**
  After an acute episode, consider individual structured psychological interventions such as CBT, in addition to prophylactic medication for people who are relatively stable but may have mild to moderate affective symptoms. The therapy should normally be at least 16 sessions over 6-9 months and:
  - include psychoeducation, the importance of a regular routine and concordance with medication
  - cover monitoring of mood, detecting early warnings and strategies to prevent progression into full episodes
  - enhance general coping strategies
  - be delivered by people who have experience of patients with bipolar disorder.
- **Family therapy**
  Consider a focused family intervention if appropriate. This should last 6-9 months and include psychoeducation, communication skills and problem solving.
- **Psychosocial support**
  Consider offering befriending (supportive relationship and activity) to people who would benefit from additional social support, particularly those with chronic depressive symptoms. This should be offered in addition to pharmacological and psychological treatments, and could be provided by trained volunteers providing, typically, weekly contact for between 2 and 6 months.
- **Promoting a healthy lifestyle and relapse prevention**
  Give patients advice (including written information) on the importance of good sleep hygiene and a regular lifestyle, the risks of shift work, night flying and flying across time zones, and working long hours, and on ways to monitor their own physical and mental state. Provide extra support after life events such as job loss or bereavement, and encourage patients to talk to family and friends. In collaboration with the individual, identify the symptoms and indicators of an exacerbation and ake a plan for how to respond (including both psychosocial and pharmacological interventions).
- **Physical health care**
  People with bipolar disorder have higher levels of physical morbidity and mortality than the general population. Implement a schedule for physical monitoring, including checks as soon as practicable after initial presentation, and monitoring of specific medications.

Pharmacotherapy guidelines

The guidance in the following algorithms is based on the best available evidence for the pharmacotherapy management of people with bipolar disorder (Yatham et al, 2009).

Manic episode

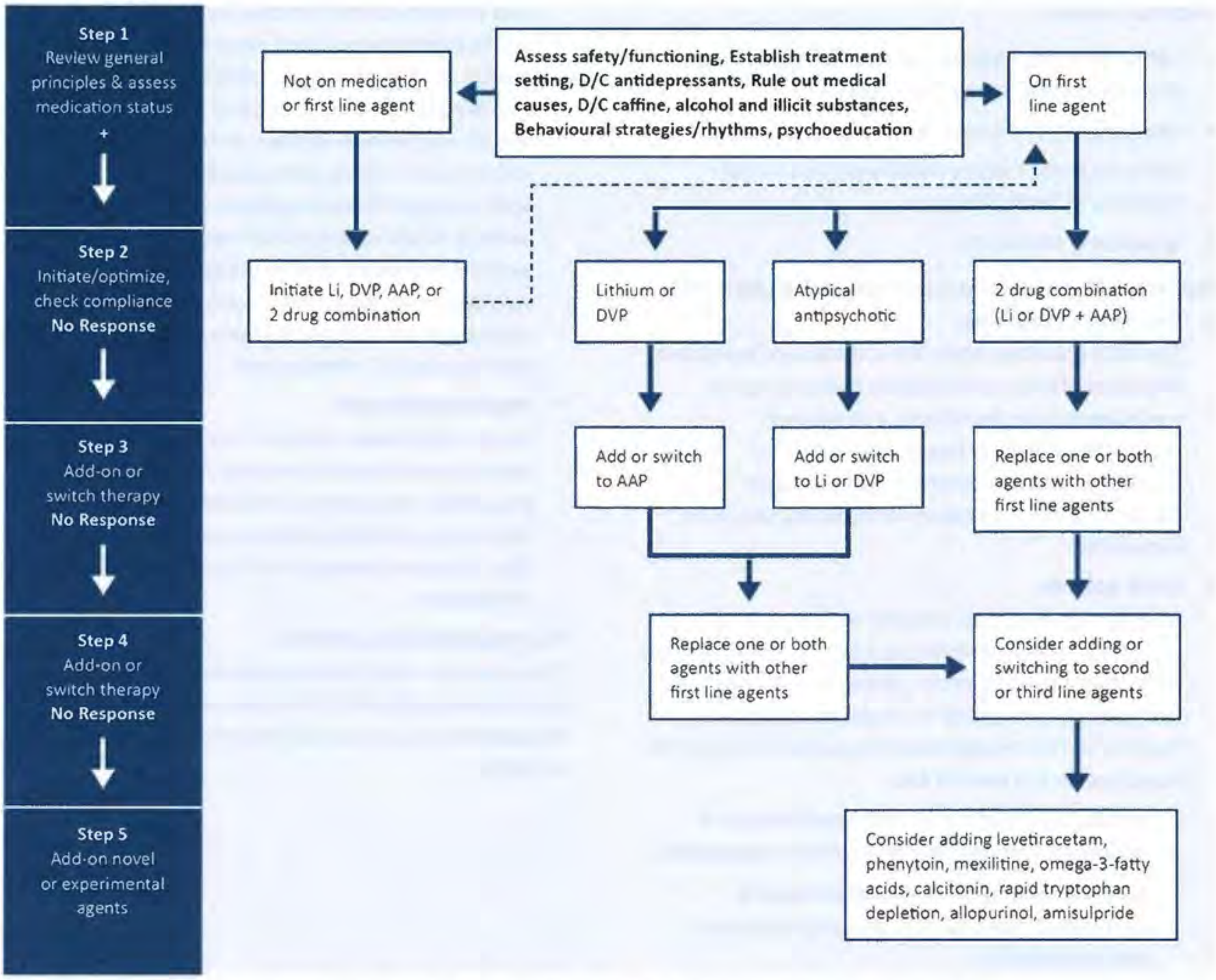


Fig. 3.1. **Treatment algorithm for acute mania.** D/C = discontinue; Li = lithium; DVP = divalproex; AAP = atypical antipsychotic.

Yatham,Y.et al. Bipolar research 2009:11:225-255

Medication for Manic Episode	
1st line drugs / treatments	Lithium, Valproate, Olanzapine, Risperidone, Quetiapine, Ziprasidone, Aripiprazole.
2nd line drugs / treatments	Carbamazepine, ECT, asenapine, paliperidone
3rd line drugs / treatments	Haloperidol, chlorpromazine, clozapine.
Not recommended:	Monotherapy with gabapentin, topiramate, lamotrigine, verapamil, tiagabine, or combination of carbamazepine and risperidone or olanzapine.

Depressive episode

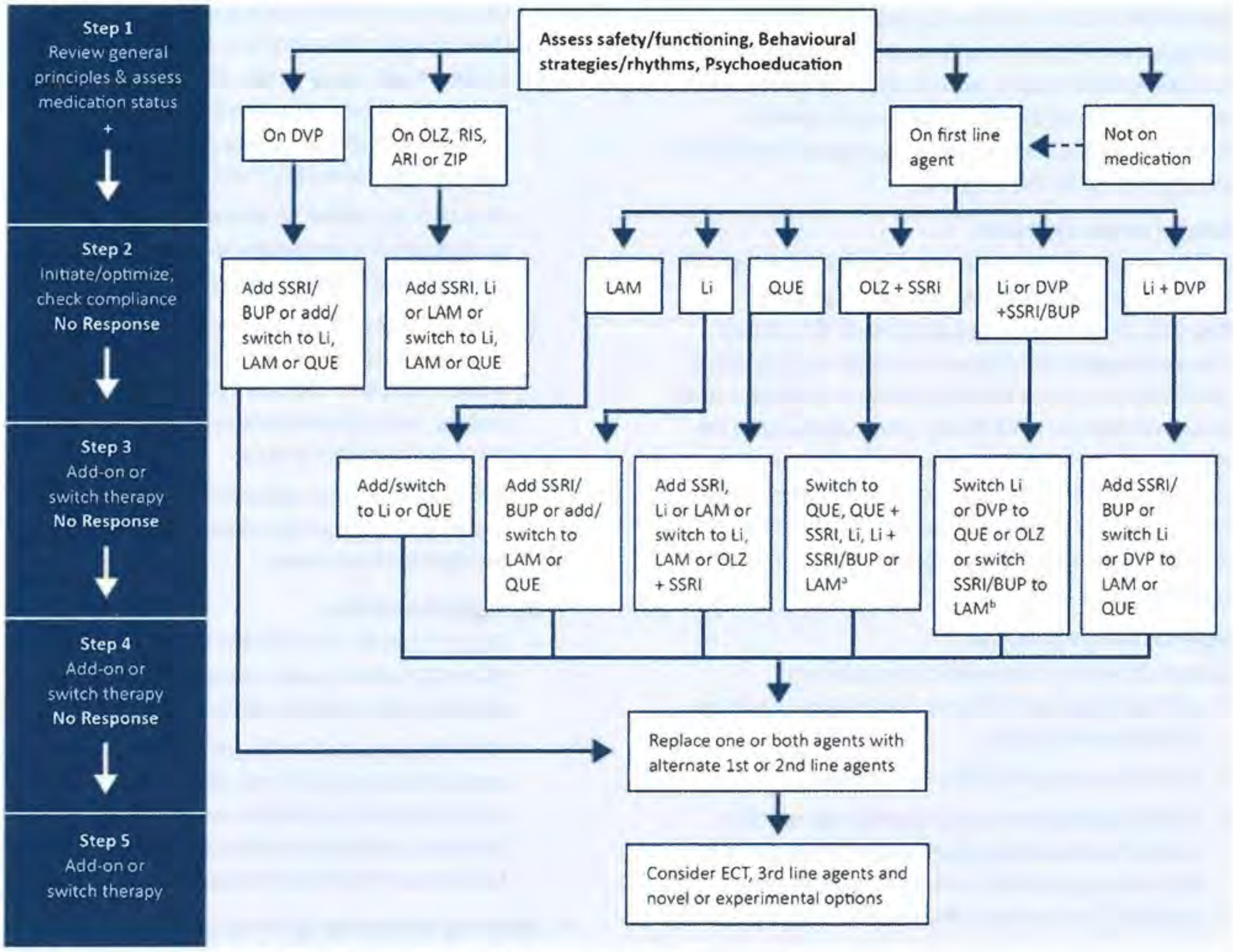


Fig. 4.1. **Treatment algorithm for the management of bipolar I depression.**
DVP = divalproex; OLZ = olanzapine; RIS = risperidone; ARI = aripiprazole; ZIP = ziprasidone; SSRI = selective serotonin reuptake inhibitor; BUP = bupropion; Li = lithium; LAM = lamotrigine; QUE = quetiapine; ECT = electroconvulsive therapy.
[a]Or switch the SSRI to another SSRI.
[b]Or switch the SSRI or BUP to another SSRI or BUP.

Yatham,Y.et al. Bipolar research 2009:11:225-255

Maintenance treatments

Recommendations for maintenance pharmacotherapy of bipolar disorder	
1st line drugs / treatments	Lithium, lamotrigine monotherapy (limited efficacy in preventing mania), divalproex, olanzapine, quetiapine, lithium or divalproex + quetiapine, risperidone LAI, adjunctive risperidone LAI, aripiprazole (mainly for preventing mania), adjunctive ziprasidone.
2nd line drugs / treatments	Carbamazepine, lithium + divalproex, lithium + carbamazepine, lithium or divalproex + olanzapine, lithium + risperidone, lithium + lamotrigine, olanzapine + fluoxetine
3rd line drugs / treatments	Adjunctive phenytoin, adjunctive clozapine, adjunctive ECT, adjunctive topiramate, adjunctive omega-3-fatty acids, adjunctive oxcarbazepine, or adjunctive gabapentin
Not recommended:	Adjunctive flupenthixol, monotherapy with gabapentin, topiramate or antidepressants

LAI = long acting injection; ECT = electroconvulsive therapy

8.4 Borderline personality disorder

The NHMRC *Clinical Practice Guideline for the Management of Borderline Personality Disorder 2012* is the basis for the following guidelines, adapted for the adult public mental health context and the NWMH Redesign. Specific adaptations for complex presentations are not covered by the Guideline.

General service principles

People with borderline personality disorder (BPD) should not be excluded from an AMHS because of their diagnosis. Clinicians treating people with BPD should follow a stepped-care approach in which an individual's usual care is based on the least intensive treatment (such as support from an NGO/PDRSS or management by GP and regular contact with a community mental health service), and referral to or provision of more intensive treatment (such as crisis intervention, a specialised BPD service, or specialised BPD programs) provided when indicated.

General clinician principles

Services should be comprised of clinicians who:

- acknowledge that BPD treatment is a legitimate use of healthcare services
- are able to recognise BPD presentations
- provide appropriate care (including non-specific mental health management, specific treatments for BPD and treatment for comorbid mental health conditions) according to their level of training and skill
- consider referral of the person to a specialised BPD service when treatment is not progressing satisfactorily
- receive regular supervision of their clinical work and seek additional consultation as required.

Non-specific mental health management

- **Diagnosis**
    - Services should be able to provide comprehensive assessment to confirm the diagnosis and any comorbidities.
- **Gaining trust and managing emotions**
    - Clinicians should be able to manage the relationship with consumers in a manner that promotes trust and mutual respect.
    - Clinicians should be aware that it is likely they will have emotional reactions, which may be intense, to individuals with BPD and their circumstances. They should try to ensure that these feelings do not lead to poor clinical decisions.
- **Setting boundaries**
    - Clinicians, the individual and appropriate others (family/carer, other service providers) should negotiate and agree on how the person will access the health service, what services will be provided and any limits of use. Agreed practices should be feasible and sustainable in the long term.
    - All staff in the health service should act consistently and predictably with the individual, guided by the management plan.
    - Even at times of crisis, clinicians should endeavour to keep the individual involved in finding solutions to their problems and participating in decision-making, within the limitations imposed by the individual's emotional state.
    - Individual clinicians, and clinicians across a service, should act consistently and predictably and set manageable boundaries.
- **Managing transitions**
    - Discontinuation of treatment should be carefully planned in advance and managed in consultation with the individual and appropriate others.
    - At the beginning of treatment the clinician should explain that the treatment, which varies according to individual circumstances, will eventually come to an end, and managing the ending may need to be a focus of treatment throughout.
- **Assessing and managing risk of self-harm or suicide**
    - General principles of psychiatric risk assessment apply when considering risk in people with BPD. The assessment should also consider the chronicity of suicidal ideation, lethality of self-harm and whether acute or chronic risk (including variation from usual baseline of risk) are relevant.

- **Management plans**
  - A tailored management plan, including a crisis plan, should be developed for all individuals with BPD who are using the service.
  - Written plans should clarify roles and actions of all clinicians involved, avoid inconsistency among treatment providers (including clear behavioural directions and options for decision points), validate the individual's concerns, have collaboratively-developed, realistic short and long term goals, be collaborative with the individual and family/carer where appropriate, and be inclusive of all service providers and others involved in care provision. There should not be multiple plans. The plans should provide the salient points of the individual's history and formulation of the problematic behaviours, be reviewed routinely at least every 6 months and whenever there is a significant change in presenting problems or circumstances, and consider specific issues of chronic and acute risk.

Treatment

Once the diagnosis of BPD is established, it should be disclosed and explained to the person, emphasising that effective treatment is available.

Psychological therapies and/or psychologically informed systemic management should be the first-line treatment in BPD. People with BPD should be provided with structured psychological therapies that are specifically designed for BPD and conducted by one or more adequately trained and supervised health professionals.

Medicines should not be used as primary therapy for BPD, because they do not change the nature and course of the disorder. The time-limited use of medicines can be considered as an adjunct to psychological therapy, to manage specific symptoms.

The majority of treatment should be provided within the community with inpatient care being offered after careful consideration of the costs and benefits. Inpatient care should be reserved for short-term crisis intervention for people at high risk of suicide or medically serious self-harm. Where used, inpatient care should be brief and directed to towards specific, pre-identified goals. When considering inpatient care for a person with BPD, health professionals should involve the person (and family or carers, if possible) in the decision, and ensure the decision is based on an explicit, joint understanding of the potential benefits and likely harm (including the likelihood of reinforcing risk behaviour in the long term), and agree the length and purpose of the admission in advance.

Clear, collaboratively developed goals and purpose for engaging are required. This mitigates against a crisis-driven working relationship. To avoid multiple therapists or interventions for BPD and comorbid mental health conditions, treatment should be integrated and concurrent, where possible.

Functional improvement goals should be considered alongside symptom treatment and referrals made as appropriate to support these goals.

Where individuals frequently access acute services in an unplanned way and are not engaging with specific psychological therapy or accepting referral, the following should be provided: a psychologically informed management plan, a coordinating clinician, family/ carer/ worker information and/or referral, risk review, and the offer of regular appointments with the treating clinician.

Families and carers

Health professionals should provide families/carers with information about BPD or direct them to sources of reliable information and support. They should also provide information about dealing with suicide attempts or self-harm behaviour. People with BPD who have babies or children should be provided with, or referred to, interventions designed to develop parenting skills and child attachment.

Organisation

Mental Health Services should:

- provide staff with information about their medicolegal responsibilities in relation to risk management and the clinical interface for individuals with BPD
- provide appropriate access to specific supervision according to their role
- review regularly their intra-team dynamics, including team members' ability to cope and their tolerance and sensitivity towards the individual
- have in place processes and structures to review individuals with BPD who are considered at high risk
- ensure that caseloads for clinicians who treat people with BPD are appropriate and realistic according to their level of experience, the needs of individuals according to their phase of treatment, the requirements of the specific treatments provided and the number of complex cases.

Consultation and collaboration

Services should communicate their principles of care and service options for individuals with BPD to other stakeholders and work collaboratively with them to support the least intensive service options. Absence of collaboration may indicate an unmet need which requires a response at the appropriate level, whether by individual workers or at the system level, using usual conflict resolution strategies.

If more than one service is involved in an individual's care, services should agree on one provider as the person's main contact (main clinician), who is responsible for coordinating care across services.

8.5 Depressive disorders *(pending)*

This section is still under development; however there are a number of useful resources for health professionals to access information, one of which is Beyond Blue and Family Focus.

8.6 Eating disorders

Eating disorders cause a high level of morbidity through their negative impact on cognitive, physical, social, and psychological aspects of health. They are associated with the highest risk of death among all psychiatric problems: standardised mortality rates for eating disorders are 12 times higher than the annual death rate from all causes in females aged 15 to 24 years of age, and up to 10% will die as a direct result of their disorder.

There has been a two-fold increase in eating disorder behaviours in the past decade, and about 15% of Australian women develop a clinically-significant eating disorder within their lifetime. In a 2005 study among youth aged 15 to 24 years, binge eating was reported by 29.3% and purging by 13.6%, and 20% were on strict diets or fasting. Body image is the number one concern among young Australians aged 12 to 25, and negative body image is a well-established risk factor for an eating disorder.

NWMH service pathways for eating disorders

The NWMH eating disorder service pathway is described in two documents:

- Triage and Clinical Pathway Flowchart, providing initial assessment based on severity and treatment pathways
- NWMH Proposed Treatment Pathway, providing a map of treatment offered to clients presenting with mild, moderate or severe symptoms

Community mental health teams will provide 6-12 months of individualised psychotherapy for moderate and severe presentations. If needed, step-up to the Royal Melbourne Hospital Eating Disorders Program (RMH-EDP) is available for more intensive treatment, ranging from outpatient therapeutic groups/dietetics, a six week Building Hope-Collaborative Carers Skills Group, 5 x 10 week day program or inpatient hospital care. The RMH-EDP will also provide formal and informal consultation-liaison for clinicians in the community teams.

Other components of the service include:

- a key worker model of two or three clinicians per community team, working specifically with eating disorder clients as part of their overall caseload
- an 'in house' training package delivered by the Victorian Centre of Excellence in Eating Disorders (CEED) in collaboration with RMH-EDP
- CEED/RMH-ED co-facilitated fortnightly to monthly group consultation for key worker clinicians.

NICE guidelines

The most commonly-recommended clinical guideline for eating disorders for adults and their families is the UK NICE *Guidelines for Eating Disorders – Clinical Guideline (*http://guidance.nice.org.uk/CG9*)*. This guideline is due for review in 2014. The following are the most relevant priorities and guidelines for NWMH.

Anorexia nervosa

In primary care:

- Although weight and body mass index (BMI) are important indicators of physical risk, they should not be considered the sole indicators.
- In assessing whether a person has anorexia nervosa, attention should be paid to the overall clinical assessment (repeated over time), including rate of weight loss, growth rates in children, objective physical signs and appropriate laboratory tests.
- Individuals with enduring anorexia nervosa not under the care of a secondary service should be offered an annual physical and mental health review by their GP.

Psychological interventions for anorexia nervosa:

- The delivery of psychological interventions should be accompanied by regular monitoring of a patient's physical state including weight and specific indicators of increased physical risk.
- Therapies to be considered include CBT or CBT-E, cognitive analytical therapy (CAT), interpersonal psychotherapy (IPT), and family interventions focused explicitly on eating disorders.
- Individual and, where appropriate, carer preference should be taken into account in deciding which psychological treatment is to be offered.
- The aims of psychological treatment are to reduce risk, encourage weight gain and healthy eating, reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery.

Outpatient treatment:

- Most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment and physical monitoring provided by a health care professional competent to give it and to assess the physical risk of people with eating disorders.
- Outpatient psychological treatment and physical monitoring should normally be of at least 6 months' duration.
- If there is significant deterioration, or the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement, more intensive forms of treatment should be considered (for example, a move from individual therapy to combined individual and family work or day care, or inpatient care).
- Dietary counselling should not be provided as the sole treatment for anorexia nervosa.

Post-hospitalisation psychological treatment:

- Following weight restoration as an inpatient, a person with anorexia nervosa should be offered outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and wider psychosocial issues, with regular monitoring of both physical and psychological risk.
- The length of outpatient psychological treatment and physical monitoring following inpatient weight restoration should typically be at least 12 months.

Pharmacological interventions:

- There is a very limited evidence base for the pharmacological treatment of anorexia nervosa. A range of medications may be used to treat comorbid conditions but caution is needed because of the physical vulnerability of many people with anorexia nervosa.
- Medication should not be used as the sole or primary treatment for anorexia nervosa.
- Comorbid conditions such as depression or obsessive-compulsive disorder may resolve with weight gain alone, without the need for medication.
- Potential medication side effects, particularly cardiac side effects, must be carefully considered because of the compromised cardiovascular function of many people with anorexia nervosa. Medications that may prolong the QTc interval on the ECG, including some antipsychotics, tricyclic antidepressants, macrolide antibiotics, and some antihistamines, should be avoided if possible. If the prescription of a medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken.
- All individuals with a diagnosis of anorexia nervosa should have an alert placed in their prescribing record concerning the risk of side effects.

Physical management:

- Anorexia nervosa carries considerable risk of serious physical morbidity. Awareness of the risk, careful monitoring and, where appropriate, close liaison with an experienced physician is essential.

Managing weight gain:

- In most individuals, treatment should aim for an average weekly weight gain of 0.5 to 1 kg in inpatient settings and 0.5 kg in outpatient settings. This requires about 3500 to 7000 extra calories a week.
- Regular physical monitoring, and in some cases treatment with an oral multi-vitamin/multi-mineral supplement is recommended during weight restoration.
- Total parenteral nutrition should not be used unless there is significant gastrointestinal dysfunction.

Managing risk:

- Risk monitoring is essential in individuals with anorexia nervosa.
- Individuals and their carers should be informed if the risk to their physical health is high.
- The involvement of a physician or paediatrician with appropriate expertise should be considered for all individuals who are physically at risk.
- Pregnant women with current or remitted anorexia nervosa may need more intensive prenatal care to ensure adequate prenatal nutrition and foetal development.
- Oestrogen administration should not be used to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses.

Bulimia nervosa

Psychological interventions:

- As a possible first step, individuals should be encouraged to follow an evidence-based self-help program.
- Consider providing direct encouragement and support for evidence-based self-help, as this may improve outcomes. This may be sufficient treatment for a limited subset of individuals.
- CBT for bulimia nervosa (CBT-BN), a specifically adapted form of cognitive behavioural therapy, should be offered to adults with bulimia nervosa. The course of CBT-BN should normally be of 16 to 20 sessions over 4 to 5 months.
- Adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.
- When people with bulimia nervosa have not responded to or do not want CBT, other psychological treatments should be considered.
- Interpersonal psychotherapy should be considered as an alternative to CBT, but individuals should be informed it takes 8 to 12 months to achieve comparable results.

Pharmacological interventions:

- As an alternative or additional first step to using an evidence-based self-help program, adults with bulimia nervosa may be offered a trial of an antidepressant medication.
- Individuals should be informed that antidepressants can reduce the frequency of binge eating and purging, but the long-term effects are unknown. Any beneficial effects will rapidly be apparent.
- Selective serotonin reuptake inhibitors (SSRIs) (specifically fluoxetine) are the antidepressants of first choice for the treatment of bulimia nervosa in terms of acceptability, tolerability and reduction of symptoms.
- The effective dose of fluoxetine in bulimia nervosa is higher (60 mg/day) than for depression.
- No other medications, other than antidepressants, are recommended for the treatment of bulimia nervosa.

Managing physical health:

- Individuals with bulimia nervosa can experience considerable physical problems that require careful monitoring.
- Fluid and electrolyte balance should be assessed in people who vomit frequently or take large quantities of laxatives.
- If an electrolyte disturbance is detected, it is usually sufficient to focus on eliminating the behaviour responsible. In the small proportion of cases where active electrolyte supplementation is required, oral rather than intravenous administration is recommended, unless there are problems with gastrointestinal absorption.

Service interventions:

- The great majority of individuals with bulimia nervosa should be treated in an outpatient setting.
- For individuals who are at risk of suicide or severe self-harm, admission as an inpatient or a day patient or the provision of more intensive outpatient care should be considered.
- Psychiatric admission for people with bulimia nervosa should normally be to a unit with appropriate experience in managing this disorder.
- Individuals with bulimia nervosa who have poor impulse control, notably substance misuse, may be less likely to respond to a standard program of treatment: treatment should be adapted to the presenting problems.

Binge eating disorder

Psychological treatments:

- As a possible first step, individuals with binge eating disorder should be encouraged to follow an evidence-based self-help program.
- Consider providing direct encouragement and support for an evidence-based self-help program as this may improve outcomes. This may be sufficient treatment for a limited subset of individuals.
- CBT for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder.
- Other psychological treatments (interpersonal psychotherapy for binge eating disorder, and modified dialectical behaviour therapy) may be offered to adults with persistent binge eating disorder.
- Individuals should be informed that all psychological treatments for binge eating disorder have a limited effect on body weight.
- When providing psychological treatments, consider providing concurrent or consecutive interventions focusing on the management of comorbid obesity.
- Suitably adapted psychological treatments should be offered to adolescents with persistent binge eating disorder.

Pharmacological interventions:

- As an alternative or additional first step to using an evidence-based self-help program, consider offering a trial of a SSRI antidepressant.
- Individuals should be informed that SSRIs can reduce binge eating, but the long-term effects are unknown. Antidepressants may be sufficient treatment for a limited subset of individuals.

Atypical eating disorders

In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, guidelines applicable to the eating problem most closely resembling the individual patient's eating disorder should be used.

8.7 Dual diagnosis

Core components of services for individuals with comorbid substance use disorders (dual diagnosis) include:

- integration of services, so that services for mental health difficulties and substance use difficulties are provided at the same time, in the same service and by the same clinicians
- staged interventions in which treatment is conceptualised as a series of stages relating to the progress of the individual through treatment over time (the person may be at different stages for different difficulties and will cycle backwards and forwards between stages over time)
- recognition that substance use disorders are long-term disorders characterised by periods of remission and acute exacerbations or relapse.

Treatment models include:

- Osher and Kofoed's engagement-persuasion model which conceptualises treatment moving through stages of engagement with the treating health professional and team. It supports the notion of persuasion of the need to change, working through treatment and then relapse prevention.
- Minkoff's Integrated Theoretical Framework, which emphasises the need to ensure initial safety and stabilisation, considers treatment to achieve acute stabilisation, and supports engagement that prolongs stabilisation and rehabilitation/recovery.

Assertiveness and motivation are key issues:

- Assertive interventions such as assertive community outreach can encourage engagement and adherence.
- Motivational interviewing can enhance the desire and ability of the individual to change their behaviour.
- Multiple psychotherapeutic modalities, for example, CBT, contingency management, group, family and social interventions, may be needed.
- A long-term perspective acknowledges that benefits accrue over time, and that improvement in people with a dual diagnosis may be slower than in those without a dual diagnosis.
- The end of interventions should not be determined by external, non-therapeutic constraints such as service policy, funding or contracts.

Dual diagnosis programs must be comprehensive:

- Treatment should focus not simply on the present features, such as substance use, but address a wide range of difficulties such as housing, finances, coping skills, relationships and employment.
- The key aim is to reduce the harmful effects of substance use in a non-judgmental and non-confrontational way.
- Cultural sensitivity and competence are essential to ensure access to, and engagement in treatment.

These core components form the basis of most integrated treatment models and underpin best-practice guidelines. Integrated treatments aim to combine evidence-based mental health and substance use interventions in an integrated way that enhances engagement and motivation.

Five phases of treatment for individuals with a dual diagnosis have been described: pre-treatment, early treatment, middle treatment, late treatment and, finally, autonomous independence. Treatment strategies can be considered for each phase of treatment against the key goals of that phase. An example is outlined below.

Pre-treatment	
Key goals	During the time between a referral being received and the initial interview it is important to: ▪ determine which is the best service to see the individual ▪ ascertain the specific needs of the individual with respect to the process of initial contact and the best people to be involved ▪ determine specific cultural needs and how these will be addressed ▪ clarify and obtain any further information that might be useful, prior to the initial interview.
Key treatment strategies	▪ Obtain any past clinical records. ▪ Involve appropriate cultural expertise when indicated. ▪ Involve the individual and family/carer at the initial engagement and prior to assessment, in order to discuss who will be involved and to ascertain cultural needs. ▪ Consider contacting the referrer to clarify the most appropriate service.

Early treatment – safety, stabilisation, assessment and engagement and motivational enhancement	
Key goals	The key goals of the initial interview are to: ▪ assess and ensure safety, including cultural safety ▪ begin comprehensive assessment and treatment ▪ attend to issues of engagement and motivation ▪ involve and engage family/carer ▪ negotiate an initial shared understanding/opinion and strategies for managing the early treatment phase. Safety requires consideration of: ▪ self-harm and suicide risk ▪ violence and risk to others ▪ medical risks (for example, metabolic disturbances such as low serum potassium associated with eating disorders, thyroid dysfunction that might underlie mood disorders, vitamin deficiencies and liver impairment associated with alcohol use, possible drug overdoses and interactions, complex drug withdrawal such as seizures and delirium, and blood-borne and other infections including HIV, hepatitis B and C and bacterial infections) ▪ cultural risks, especially for those whose identity lies outside the mainstream (for example in ethnicity or sexual orientation), working to ensure that the person does not feel demeaned or invalidated by the processes of assessment, treatment and interventions ▪ ability to care for self and dependants safely, especially children. Stabilisation involves: ▪ the short-term management of acute crises and severe dysfunction ▪ treatment of acute mental health crises ▪ acute management of intoxication and withdrawal ▪ initial stabilisation of substance use ▪ management of acute lifestyle crises such as relationship issues, homelessness etc (sometimes the individual may attribute lack of stability to aspects of their life including the spiritual dimension) ▪ consultation with, or referral to, another specialist agency if required. Assessment involves the mental health assessment with emphasis on: ▪ recent and lifetime substance use history ▪ exploring the relationship between the substance use and other mental health symptoms ▪ stage of change regarding substance use ▪ physical assessment including physical examination and investigations. Engagement and motivational enhancement involves: ▪ identifying the individual's own hierarchy of needs and attending to the most urgent ▪ initiating the individual's consideration of the impact on substance use on their health, lifestyle, etc.

Middle treatment		
Key goals	The key goals for middle treatment are: ▪ active treatment of mental health and substance use problems ▪ increasing the focus on steps to enhance well-being ▪ maintaining engagement and motivation.	
Key treatment strategies	1. Setting	This may take place in either community or residential settings. Consider: ▪ the key clinician's role ▪ continued use of the Mental Health Act if needed, community-based if possible ▪ treatment within Justice settings or in residential or community settings ▪ collaboration with other agencies e.g. AOD service.
	2. Further information	Consider: ▪ collaborative history regarding progress of the management plan. ▪ urine drug screens to provide feedback on progress.
	3. Treatment of medical conditions	Consider: ▪ continuing treatment of current and pre-existing medical conditions ▪ monitoring and enhancement of general physical well-being ▪ consultation and communication with other medical treatment providers e.g. GP, addiction physicians, other medical specialists.
	4. Psychopharmacology	Consider: ▪ initiation and/or maintenance of medications for both the substance use disorder and the other mental health problems, as for the early treatment phase, if not already started ▪ monitoring of dose, adherence, response and potential toxicity ▪ repeated review of treatments and their impacts: augmentation or change of medication if required or ineffective.
	5. Psychological interventions	Many psychological interventions aimed at actively treating the core substance use and mental health problems will be initiated in the middle phase of treatment, guided by what is known to be efficacious, individual acceptability and clinician's competence. Consider: ▪ psychological treatments, especially CBT for psychiatric conditions such as addiction, anxiety disorders (including post-traumatic stress disorder), depression; and specific skills building (coping, problem-solving, social skills) ▪ motivational approaches ▪ 12-step facilitation ▪ relapse prevention for substance use and mental health difficulties ▪ coping skills, social skills training ▪ contingency management.
	6. Family and social interventions	Consider: ▪ family/carer education about the assessment and management plan for the individual, and about strategies the family can use to support recovery ▪ family therapy ▪ further treatment for significant others and family members' own difficulties, if appropriate ▪ peer support/mutual help groups e.g. AA, NA ▪ social activity groups ▪ multi-systemic therapy, social behavioural network therapy; ▪ occupational therapy for assessment and rehabilitation of work skills, daily living skills ▪ various community support agencies.
	7. Spiritual interventions	As for early treatment.
	8. Education/ work/occupation	Consider: ▪ further education, work and occupational skills; work opportunities.

Late treatment		
Key goals	The key goals for late treatment are: ▪ maintenance of minimised substance use and mental health symptoms, including: – ongoing relapse prevention, coping skills, social skills, treatment adherence – maintaining engagement and motivation ▪ restoration of well-being, rehabilitation and recovery, including: – supported transition to effective community functioning – ongoing work on relapse prevention, coping skills, social skills, treatment adherence – enhancement of well-being and the development of supportive social networks – improved family functioning – employment. ▪ increasing recovery and self-management, including supporting the individual to independently apply the strategies above.	
Key treatment strategies	1. Setting	This point in treatment should usually be undertaken with an individual who is in a stable, independent home environment, or who is transitioning to this in the very near future. Case management should continue but will be increasingly supportive rather than therapeutic. Consider: ▪ reviewing the collaborative history regarding the progress of the management plan ▪ performing urine drug screens to provide feedback on progress.
	2. Further information	As above.
	3. Treatment of medical conditions	Consider: ▪ continued treatment of pre-existing medical conditions ▪ monitoring and enhancement of general physical well-being.
	4. Psychopharmacology	Consider: ▪ medication will generally be established and stable at this point in treatment ▪ ongoing monitoring of treatment adherence, while increasingly giving the individual and family/carer responsibility for managing medication.
	5. Psychological interventions	Consider: ▪ a shift in focus direct psychological interventions to supporting the individual to apply them in their day-to-day lives ▪ reinforcement of previously learnt coping skills and other strategies.
	6. Family and social interventions	Consider: ▪ increasing education about the specific strategies used in treatment and transition of the clinician's supportive role to significant others and family/carer ▪ encouraging the establishment of non-substance using and pro-social peer relationships.
	7. Spiritual Interventions	As above.
	8. Education/ work/ occupation	Consider: ▪ the individual engaging in work, ongoing learning and leisure activities.
	9. Discharge planning	Consider: ▪ referral to continuing care providers e.g. primary care, GP, private sector, other specialist services e.g. AOD service.

8.8 Antisocial personality disorder

People with an antisocial personality disorder (ASPD) may present for assessment and require treatment from an adult mental health service. Most often this occurs because the ASPD is a comorbid diagnosis with a mental illness or another personality disorder which falls within the criteria for treatment from the service, or in the context of a crisis presentation. As a result, treatment planning may be complicated by the presence of competing needs. Treatment planning for the presenting disorders should account for the risks in providing or modifying usual treatment, according to the individual's circumstance. Decisions should be made after a careful analysis of the respective risks to the individual and others, balanced against the need for treatment.

Assessment

When assessing a person with possible ASPD during a usual psychiatric assessment, consider:

- antisocial behaviours including the context and circumstances of the behaviours
- the history of previous violence, as an important guide to the development of a violence risk management plan
- personality functioning, coping strategies, strengths and vulnerabilities
- comorbid mental disorders, including depression, anxiety, substance misuse, post-traumatic stress disorder and other personality disorders
- the need for psychological treatment, social care and support, and occupational rehabilitation or development, and whether this will need to be modified to accommodate the ASPD traits
- any history of domestic violence and abuse
- collateral history, whenever possible, to increase the validity of the assessment, including any contact with other treating services and justice settings
- the use of measures such as Historical Clinical Risk-20 (HCR-20) to assess the risk for future violence if there is a known history of violence.

When a person with learning or physical disabilities or acquired cognitive impairments presents with symptoms and behaviour that suggest ASPD, staff involved in assessment and diagnosis should consider consulting with a relevant specialist practitioner or specialist service.

Management

- Make sure boundaries are maintained. Do not disclose clinicians' personal details.
- Maintain a polite and respectful attitude, but be clear about the purpose of the service and the limits of your role.
- Set clear limits and the define the response to threats. Take threats seriously and inform the person that such behaviour will have consequences including reports to police.
- Ensure all staff have skills appropriate to the nature and level of contact with people with ASPD. These include:
  - for all frontline staff, knowledge about ASPD and an understanding of behaviours in context
  - awareness of the potential for therapeutic boundary violations
  - knowledge of assessment procedures used within the service
  - for staff with regular and sustained contact with people with ASPD, the ability to respond effectively to the needs of individuals in a balanced way
  - for staff with direct therapeutic or management roles, competence in the specific treatment interventions and management strategies used in the service
  - considering a referral to forensic services where there is a history of serious violence, including predatory offending, stalking or targeting of children or other vulnerable people; or where there is a current threat of violence to known persons including staff.

Treatment

- Offer treatment for mental illness in line with the relevant clinical guideline, where available.
- When starting and reviewing medication, pay particular attention to issues of adherence and the risks of misuse or overdose.
- Keep pharmacotherapy to a minimum. Do not prescribe medications likely to carry risk of abuse such as benzodiazepines or atypical antipsychotics such as quetiapine.
- Be aware of the potential for, and possible impact of, poor adherence to treatment, high attrition, misuse of prescribed medication, and medication interactions (including with alcohol and illicit drugs).
- Pharmacological interventions should not be routinely used for the treatment of ASPD or associated behaviours of aggression, anger and impulsivity, in the absence of a mental illness that is appropriately treated with medication.
- People with ASPD are more likely to benefit from therapies where there are clear limits, structured approach and a focus on particular areas of concern such as interpersonal difficulties.
- Keep inpatient admissions to a minimum. In general, consider admission only for the treatment of mental illness disorders or for unavoidable crisis management.

Supervision

Services should ensure that staff supervision is provided routinely, and that it is properly resourced and is monitored. Staff providing interventions for people with ASPD should receive high levels of support and close supervision, due to the increased risk of harm.

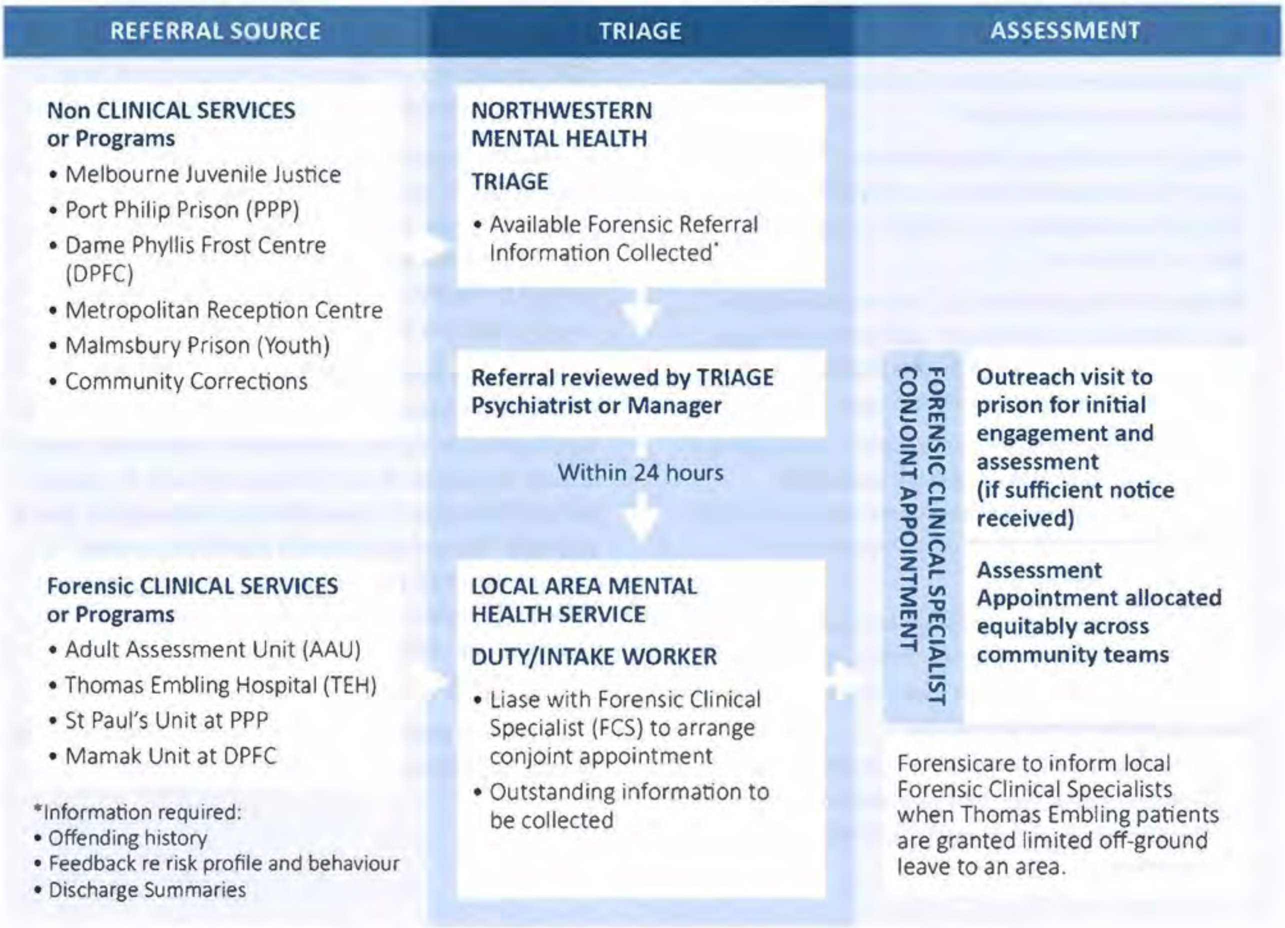
Supervisors should consider the use of direct observation, for example, recordings of sessions, and routine outcome measures; support adherence to the specific intervention/treatment regimen; promote general therapeutic consistency and reliability; and counter negative attitudes among staff.

Collaboration and consultation

Provision of services for people with ASPD often involves significant inter-agency collaboration. Therefore, services should ensure that there are clear pathways for people with ASPD so that the most effective multi-agency care is provided. The pathways should specify the various interventions that are available at each point, enable effective communication among clinicians and organisations at all points, and provide the means to resolve differences and disagreements.

The following table outlines the NWMH pathway of entry to care for individuals with a forensic background.

8.9 Forensic package



REFERRAL SOURCE

Non CLINICAL SERVICES or Programs

- Melbourne Juvenile Justice
- Port Philip Prison (PPP)
- Dame Phyllis Frost Centre (DPFC)
- Metropolitan Reception Centre
- Malmsbury Prison (Youth)
- Community Corrections

Forensic CLINICAL SERVICES or Programs

- Adult Assessment Unit (AAU)
- Thomas Embling Hospital (TEH)
- St Paul's Unit at PPP
- Mamak Unit at DPFC

*Information required:
- Offending history
- Feedback re risk profile and behaviour
- Discharge Summaries

TRIAGE

NORTHWESTERN MENTAL HEALTH

TRIAGE

- Available Forensic Referral Information Collected*

Referral reviewed by TRIAGE Psychiatrist or Manager

Within 24 hours

LOCAL AREA MENTAL HEALTH SERVICE

DUTY/INTAKE WORKER

- Liase with Forensic Clinical Specialist (FCS) to arrange conjoint appointment
- Outstanding information to be collected

ASSESSMENT

FORENSIC CLINICAL SPECIALIST CONJOINT APPOINTMENT

Outreach visit to prison for initial engagement and assessment (if sufficient notice received)

Assessment Appointment allocated equitably across community teams

Forensicare to inform local Forensic Clinical Specialists when Thomas Embling patients are granted limited off-ground leave to an area.

8.10 Adults with intellectual disability

Intellectual disability is associated with an increased prevalence of mental illness which is often unrecognised and untreated. People with an intellectual disability tend to have a longer duration of inpatient admissions and have a greater need for high-dependency care or specialling. There may be challenges in determining suitable accommodation and support options, so close liaison with family and disability services is important.

In people with limited speech it may be particularly difficult to obtain a history, but changes in behaviour or functional ability may be important signs of a deteriorating mental state. It is important to listen to the views of family and carers and to note any change in behaviour. Management in the community or in an inpatient setting requires sensitive appreciation of how the person views their situation. Where there is concern about the diagnosis or appropriate treatment, consultation with the Victorian Dual Disability Service may be helpful.

Assessment

Severity of impairment should be based on adaptive functioning rather than IQ test scores alone. Careful assessment across conceptual, social and practical domains will assist treatment planning.

Assessment should aim to distinguish between problems which may be associated with another psychiatric disorder and problems arising out of intellectual disability itself. Information about the person's baseline mental state, before the onset of new problems, is essential to the assessment process.

Relevant issues in the history include:

- Family history of intellectual disability, psychiatric illness, neurological (epilepsy, dementia) or other relevant illness, and the quality of important relationships between the person and other family members.
- Personal and developmental history, including information about the pregnancy and birth, developmental years (including milestones), education and job history, relationships with others at school and at employment or day placements, the family's management of the child with an intellectual disability, personality and behaviour prior to the development of the psychiatric illness, psychosexual history, notable life events (especially loss, abuse, and changes in placement or carers), and the highest level of functioning that the person reached.
- Medical history, including the cause of the intellectual disability and, if known, past and present physical illnesses (including epilepsy, sleep apnoea, thyroid disorder), past and present physical disability (such as limb weakness or spasticity), impairment in vision, hearing, speech or mobility, recurrent physical illnesses (for example chest infection, toothache, constipation). Try to establish how the person communicates pain or any other bodily discomfort.
- Psychiatric history, including previous history of contact with services, diagnoses (supported by a description of the clinical picture if possible), and assessment of the risk to the person and others.
- Social history, including current and previous level of functioning in different areas of adaptive behaviours, current and previous social circumstances, current and previous living arrangements, current and previous social support (for example quality and quantity of carer support, daytime activities, social and leisure activities). Assessment of the person's daily or weekly routine can help gather this information.
- Medication and substance use history, including past and present medication (psychotropic and others, including dosage), history of adverse side effects, recent change in medication, substance and alcohol use, and know allergies.
- Forensic history, including any past or recent problem with the law, both for the person and their friends and family.
- History of the presenting complaint.

As far as possible, the person should be assessed in a surrounding that is familiar to them. The usual requirements for consent and confidentiality must be considered. If it is determined that the person is able to consent, then their views about confidentiality should be sought. If the person does not have capacity to consent, it is appropriate to determine whether the person has a guardian, and what information needs to be shared to support ongoing treatment and care.

Communication

Psychiatric assessment relies heavily on the reported experiences of the person. People with an intellectual disability may have a limited capacity to convey their subjective experience, so usual assessment techniques may need to be modified in order to gather accurate information.

Asking some general, easy questions at the start of the interview will help put the person at ease. Assessment of the person's communication ability is necessary at the outset. In some cases it will be appropriate to use visual aids such as pictures, drawings or picture books to assist with the assessment.

As much as possible, speak to and involve the person themselves during the assessment. Avoid the use of leading questions, where possible. Use appropriate language, such as simple phrases and short sentences, avoiding complex metaphors, idioms or words, phrases or expressions that the person may not understand (including medical jargon). Repeat questions if needed. If there is doubt that the question has been understood, then ask the person to repeat the question back, or explain what has been asked.

Minimise suggestibility when asking questions. Leading questions are not useful. For example: *'You don't like living there, do you?'* should be avoided. A better question may be *'What is it like in your home?'*

Where possible, open questions should be used. For example: *'How are you feeling today?' 'What do you like doing at the (day) centre?' 'Tell me about...'*

Closed questions may sometimes be necessary to clarify a particular issue. Where closed questions are used, be careful to avoid suggestibility. For example, if the question *'Do you feel sad?'* were asked, then the interviewer could ask: *'What do you do when you feel sad?'* or *'Do you feel happy?'* (contradictory question). Ideally, contradictory questions should be asked later in the interview rather than immediately. Closed questions can sometimes be avoided by asking questions with multiple choices.

Stop every so often, and ask the person to feed back to you things that you have said to them, to ensure comprehension.

Observation

In some cases, it may be necessary to ask an observer, such as the family/ carer, about any changes shown in the person's mental state. Ideally, the observer should have known the person over a period of time so they can describe the new symptoms or changes in the quality or intensity of existing symptoms. It may also be necessary to ask a carer or family member to monitor, over time, variables such as sleep, appetite, weight, level of activity or specific behaviours, to aid the diagnosis. However, direct observation of the person by the clinician is always necessary.

Part four:
Keeping the guide relevant

Part 4: Keeping the guide relevant

9. Sustainability of the Practice Guide

9.1 Governance roles and responsibilities

A group of NWMH staff will assume responsibility for ensuring this Guide reflects current evidence and practice. The group will reflect disciplines encompassing medicine, nursing, occupational therapy, psychology, and social work, as well as consumer and family/carer perspectives.

The following activities are recommended on an annual basis:

- annual review of the literature
- bringing expertise from the field
- considering the need to set up a special interest group
- consultation with recommended expert panels (university partners, peak bodies, etc)
- updating the Guide accordingly
- considering any need to update policy/procedure, governance arrangements, operational processes and any other recommended activities
- reviewing NWMH professional development and training priorities to remain up-to-date and to address any areas of development in our skills.

9.2 Orientation, education and supervision strategy

Strategy for training, supervision and support

To achieve the principles, goals and outcomes of a redesigned adult community mental health program, NWMH has committed to a strategy that supports staff through training, ongoing supervision and mentoring.

The strategy required to facilitate and sustain improvements in the quality of service provision must be consistent with the endorsed goals, practice guide, policy changes and systems developed.

A capability survey will identify the depth and breadth of current skills and knowledge. Data from this survey, together with management input, will identify current strengths and give an initial indication of the training needs within the new framework. The survey will identify existing staff with transferrable skills and knowledge to assist with training.

The Melbourne Health Capability Framework provides for the development of staff on a continuum from foundation, to consolidation, to mastery of requisite capabilities. Programs of learning will be developed in accordance with this Framework to assist staff at all levels of development to achieve the skills and knowledge for their role.

The key elements to the workforce support through education and training are as follows:

- Education and training will provide foundation and consolidation of the skills, knowledge and attitudes required for recovery-oriented community practice.
- Support programs will address each of the functional elements of the teams: point of entry screening/review; crisis assessment and response; face-to-face assessment; recovery/needs planning; reviews and transition planning.
- Training will address the advanced skill set required for intensive service delivery, and targeted short-term and longer-term evidence-based responses.
- The majority of learning will be inter-professional, occur in the workplace, and be undertaken as a team. Where possible learning will be facilitated 'from within', capitalising on existing capabilities.

Support for learning

Individuals and teams will have access to a wide range of relevant support and development options including training, education and various forms of supervision. Every community team member will have either a formal or an informal role in supporting his/her colleagues through the implementation of a collaborative and inter-dependent work environment.

New support and development strategies within the new Framework will augment and complement the work of existing programs such as the NWMH Mental Health Training and Development Unit (MHTDU) and the Western Cluster, Substance Use and Mental Illness Treatment Team; ORYGEN YOUTH Communications and Training, and the Centre for Excellence in Eating Disorders.

The strategies will also be consistent with MH Education Strategy's Goals for Education (2011-2015), which are to:

- translate learning into practice
- create collaborative learning environments
- promote relationships that advance a learning culture
- align education initiatives with organisational objectives
- demonstrate a commitment to learning and development.

Support through supervision structures and processes

Staff transitioning to the Community Teams as part of the *Redesign* will be supported by a robust supervision framework drawing upon the Victorian Department of Health (2006) guidelines for the provision of supervision in mental health and community settings. Every direct care staff member will have access to line, professional, multi- or interdisciplinary and specialist practice (therapy oriented) supervision. Clinical supervision may involve individual, group or peer approaches, and can be informed by a variety of theoretical perspectives.

The responsibility for supervision is shared between the leaders of discipline, managers and the members of the clinical team. Each profession will be responsible for supervision requirements for their profession, and such supervision is termed 'professional supervision'. In addition, supervision focussing on enhancing practice, in terms of an orientation towards recovery within the Community Teams, will take the form of individual, group and peer supervision as determined by each team and individual need.

Each Community Team will examine the opportunities for supervision practices that maximise the embedding of a recovery-oriented culture, utilising internal senior skilled staff to contribute to the local supervision structure and processes. In particular, opportunities for inter-professional collaborative supervision will be pursued.

Guiding principles and assumptions

The strategy and the domains described here are founded on the perspective of the learner, so the outcomes and focusses are learner-centred rather than training-driven. The approach to development of capability is driven by the pursuit of learning as 'individual and team understanding' rather than the delivery of discrete content-focussed curricula.

NWMH has an established reputation for delivering continuing education and training. To provide the additional developmental support for staff involved in the redesign, learning activities will be driven by the following principles:

- Dedicated regular team professional development sessions of a minimum of two hours weekly will be built into team work timetables and individual role expectations, and will be a required activity of all staff.
- The community services will be recovery-oriented and evidence-informed and, in turn, learning activity will reflect these principles.
- Workforce capability development is a continuous learner-centred pursuit through team-based practice development activity.
- The predominant approach will be team-based learning supported by evidence and expert experience.
- Systems will recognise strengths. In particular, it is acknowledged that expertise exists within our services to perform the clinical roles and to deliver most knowledge transfer goals.
- Every staff member will have a current individual development and work plan accounting for needs raised by redesign.
- Sustainability is achieved through practice supervision and skills coaching.
- Localised workforce learning governance will be provided by collaboration between team managers, area discipline seniors, and expert clinical staff.

Learning domains

The following four learning domains will help structure strategic activity to support staff in transitioning into roles and embedding sustainable practice change within our Adult Community Mental Health Services. The learning domains are not mutually exclusive but, instead, are inter-dependent: each domain (or outcome) may inform the others.

Domain 1: Leadership and team development

This domain supports team managers and team leaders with:

- a comprehensive overview of the Framework for Care, NWMH systems and local service systems and structures developed to support redesigned community mental health programs
- support to lead change in the team and promote team cohesion and development
- an understanding of organisational recovery-oriented practice
- promoting a team culture of reflection and learning.

Staff will be assisted through the process of team establishment and development by a staged induction to the newly formed teams.

Domain 2: Orientation to service system

This domain ensures staff are confident and able to work within the structure, functions and systems of the adult community care program. This domain will orient staff to system functions including new protocols, processes and relationships. Team and individual learning needs will guide the direction of learning practices.

Domain 3: Enhancing recovery-oriented practice

This domain supports teams in embracing practices that are consistent with principles of clinical and personal recovery by:

- maximising staff understanding of the philosophy and principles of recovery as well as the specific approach to recovery described in the Framework for Recovery-Oriented Practice (DoH 2011)
- enhancing the organisational culture to embrace and implement the philosophy and goals of recovery-oriented practice.

NWMH has endorsed the Victorian Department of Health (2011) Framework for Recovery-oriented Practice. The best available evidence will be incorporated into learning programs and service systems as new developments in recovery-oriented service delivery become available: for example, the Commonwealth is currently developing a National Framework for Recovery-Oriented Mental Health Service.

For the purpose of this learning and support strategy, a number of the nine domains of the Framework are combined to create six areas of development.

Domain 4: Evidence-informed practice

This domain will ensure staff have the opportunity to acquire and maintain:

- foundation skills and knowledge in care delivery
- consolidation of evidence-informed interventions
- mastery (credentialing) of specific evidence-based therapy.

'Foundation skills' refers to the fundamental skills and knowledge used regularly in practice by all clinicians and includes refresher and update learning required for core clinical practices.

'Consolidation' refers to specific therapeutic interventions where the clinician is using concepts or tools in an organised way and that are informed by evidence. All clinicians will be expected to develop, in time, the capability to employ at least one such approach.

The notion of 'mastery' is used to describe advanced knowledge and skill that supports the use of clearly identified and evidence-validated therapies. It is anticipated that, in time, each team will possess some capacity for the delivery of care at this level.

9.3 Feedback and updating

Any feedback on this Guide can be emailed to Belinda.McCullough@mh.org.au

How content is reviewed and endorsed?

The first revision of the Guide will occur within 6 – 12 months. The content revision will be developed, consulted broadly and endorsed by a NWMH leadership group, whose membership will include representatives of all discipline groups – allied health, consumer, carer, medical and nursing, with representation across all four adult community services.

Part five: Resources

Part 5: Resources

10. Glossary and abbreviations

Carer: A person who actively provides support or care for a person with a mental illness with whom they have an ongoing relationship. The carer/support person need not necessarily live with the person with a mental illness. A carer can be a family member, friend or other person, including a child or young person, who has a significant role in the life of the person with mental illness. The role of carer may not necessarily be a static or permanent one but may vary over time according to the needs of the consumer and carer. A carer may not necessarily be the next of kin.

Clinical treatments and interventions: Treatments and interventions that arise from a professional knowledge base, for example CBT, medication, multiple-family groups, to support an individual's personal recovery.

Consumer/carer peer support worker: A peer worker is someone with lived experience who is trained and paid to work in a formalised role in support of others in recovery. It is someone who is willing and able to share this experience on an equal level that supports, empowers and brings hope to the people they are working/partnering with. The peer principle is based on learning together through empathy and mutuality which are critical to empowerment. Peer workers use a strength-based approach to help the other recognise their own potential.

Family/carer: NWMH uses this term to acknowledge the range of adult and child family members, including those who may or may not identify as carers of their family member with a mental illness.

Family: Biological or chosen family as defined by the consumer, for example spouse/partner, dependant and adult children, parents, siblings, grandparents.

FaPMI: Families where a Parent (of a dependent child) has a Mental Illness. A FaPMI focus includes supporting parent consumers and their dependent children (0-18 years) through a recovery-family focused approach.

Abbreviations

ACPR	Adult Community Project Redesign
CALD	Culturally and Linguistically Diverse
CCAG	Consumer Carer Advisory Group
CATT	Crisis Assessment and Treatment Team
CIIC	Clinical Improvement and Innovation Committee
CMI	Client Management Interface
CMHT	Community mental health team
ESIC	Evaluation and Service Improvement Coordinator
KPI	Key Performance Indicator
NMHCCF	National Mental Health Consumer and Carer Forum
MHCA	Mental Health Council of Australia
NWAMHS	North West Area Mental Health Service
NWMH	North Western Mental Health
PDRSS	Psychosocial Disability Rehabilitation Support Service
RCT	Randomised Control Trials

Click here for the NWMH all Abbreviations

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12. Appendices

12.1 What do we currently provide? Index of current treatment and specialist assessments

As part of the process to develop the Practice Guide all areas and discipline groups were asked to map the evidence informed care that they provide. This process provides an excellent audit of care we currently provide and evidence for various treatments. We encourage you to access this information and we intent to update it within the annual review period.

Click here for more indexes

12.2 Recommended carer support options

Click here for documents

12.3 Mental health triage scales

Click here for more information

12.4 Algorithm

Click here for more information

12.5 Eating disorder flow chart and proposed treatment pathway

Click here for flowchart

click here for pathway

12.6 Consumer report

Processes and Systems to Best Identify and Capture Consumer Needs: Final report and recommendations from consumer consultations

Prepared by Wanda Bennetts: August 2012

1. Purpose and content of report

This report was used to inform the NWMH Adult Community Program Redesign (ACPR) and make recommendations on what systems and processes will best identify and capture consumer needs from the perspective of consumers.

The purpose of this report is to inform:

- A description of the tasks and how they relate to the overall ACPR framework
- An outline of the methodology used to inform the recommendations
- An outline and explanation of the recommendations
- Further issues for consideration

Attachments:

- Suggested guidelines/questions from consumers regarding needs identification (Attachment A)
- List of people consulted (Attachment B)
- References (Attachment C)

2. Description tasks

The key deliverables were outlined as:

- An agreed set of questions in order to identify needs
- A recommendation about *how* the collection of information about needs is best-facilitated
- A recommendation about *when* the collection of information about needs should be undertaken

3. Methodology

First step was to devise a question that outlined best practice and determined consumer need(s), consultations were used as a way to get the information. The first question was: 'Does anyone have any good questions they think should go into an assessment with respect to finding out what consumers need from services?'

Process:

a) Consultation to VMIAC consumer workforce *(list made available via VMIAC Information Officer*); to NWMH CCAG; and to four local CAG meetings.

b) Further information was gathered through ACPR Consumer Consultant attendance at:
   - The VICSERV Conference
   - The VMIAC Consumer Workforce Conference
   - The Mary O'Hagan Consumer Leadership Workshop
   - The National Recovery Forum key note presentations from Mike Slade and Ken Thompson

c) All responses and data were collected and collated as raw information.
   - Raw information refined and draft documentation circulated to consumer group for feedback
   - Draft document reviewed and refined by 2 local CAG's to seek validation of content and sentiment of the document. At these consultations, the process of how and when questions should be asked was also explored.
   - Objective drafted
   - Two-hour workshop held with the NWMH CCAG to validate content and final feedback for consideration.
   - Final report written and presented to both NWMH CCAG and the ACPR Executive

4. Outline Recommendations

- Identifying the needs of consumers as determined by consumers.
- By capturing the input of consumers in relation to assessing needs.
- Connecting with the person most important and the clinician's approach (inclusive of body language)

Recommendation I: Early and safe engagement

- Engagement is about making connections with people.
- Making connections with people is the basis for building a relationship that creates a safe space for consumers to be able to trust and work with clinicians.
- Consumers know when this connection is genuine and or authentic and compassionate. A connection that comes from both the heart and the head.
- Building a relationship that helps people to connect may take time and will be different for every person, but should begin immediately.
- From a consumer perspective, it is considered that this will mean that the rewards will be greater.
- Consumer needs can be many and varied. There is no 'one size fits all'
- Flexibility, skill and clinical judgment from the clinician are required. This is an essential focus in understanding
- Creating a safe and welcoming environment – consumers noted that simple things like a genuine smile, making eye contact and offering a cup of tea or coffee are incredibly powerful in helping them to feel safe, welcome and settled.
- Having a conversation may work best for *some* people, as opposed to what sometimes feels like a barrage of questions.
- Acknowledging the importance of partnership - this includes allowing the consumer to take a lead in what is important for them, being aware of your own personal style and strengths as a clinician so that interactions are authentic and comfortable for clinicians too. It is also about engaging other key partners in care *(see carer report).*

Recommendation II: Guided by a 'personal' recovery approach

- Understanding recovery from a consumer perspective which may differ from a clinical perspective on recovery is useful (Slade, 2009).
- Understanding the tensions of 'clinical recovery' approaches (e.g. treatment and clinical outcomes such as symptom reduction within a legislative framework) and a 'personal recovery approach (e.g. driven by self determination, choices, hope and holistic needs); where illness may not be the most important thing to 'fix ' or address.
- A personal approach puts the expertise of the person in the driving seat, where they can use their expertise about themselves to direct and shape treatment.
- Some suggestions around using a personal recovery approach were:
- That the 'Framework for recovery-oriented practice' (DoH, 2011), its values and consequent practices are embedded in the therapeutic relationship, staff selection, professional development, and staff support structures and processes (especially education, training provided by NWMH, performance management, and supervision).
- Work around culture change commence with developing processes and strategies that relate to the domains from the 'Framework for recovery-oriented practice' (DoH, 2011). Example:
    - 'Promoting a culture of hope'
    - *Use hopeful and recovery oriented language in all interactions and documentation (DoH, 2011, p.7)*
    - *Actively seek and share (with permission) people's stories of recovery (DoH, 2011, p.8)*
    - *Broadcast research on recovery outcomes and create opportunities for service-wide discussions of the research (DoH, 2011, p.8)*
    - 'Promoting autonomy and self determination'
    - *Provide all the necessary information to support people to make decisions about their mental health care equivalent (DoH, 2011, p.9)*
    - *Use advance directives, advance statements or equivalent (DoH, 2011, p.10)*
    - *Review local policies and procedures to incorporate principles of autonomy, self-determination and choice equivalent (DoH, 2011, p.10)*

Recommendation III: Helping the person to create a positive identity

Focusing on strengths that make the person feel that they have something worthwhile to contribute is much more powerful than focusing on problems. When people are asked about their needs as if they are 'problematic' and 'different', it has the potential to create a negative or a 'sick' identity (Mary O'Hagan, 2012). Asking what is happening for you or what has happened to you, rather than what is wrong with you is much more likely to help the person to express and uncover things that can help to connect with what is really important and not make people feel like they are 'the problem'. Using a strengths based approach is also helpful in providing a strong foundation to build upon and to use as the basis of a relationship with the treating clinician.

A suggestion from the consultations was to ask the questions:

- What do you do well?
- What are your strengths?
- What is your passion?

These questions can be asked when it feels right – possibly at the first meeting or even several meetings down the track. Using clinical judgment was considered to be very important.

Recommendation IV: Providing a clear and realistic explanation of the service and what the person might expect from you

Helping consumers to understand why they are with you and what they can expect from you and the service is very helpful. Letting people know early in the interactions what they can expect means that people don't have false expectations and it opens the door for further conversations about what and where they might get what is needed.

Examples of what consumers thought would be good to know are:

- What the service can and cannot provide
- That you may need to refer to someone else for some things to be addressed (explain what these things may be)
- That you don't expect people will use services forever

Recommendation V: Identifying needs from a consumer perspective

Finding out what the person needs *as determined by the person* is critical. Also, it can be quite distressing or annoying for people to have to tell their story over and over, although some people may want to make sure you hear it directly from them. To help with this, some suggestions below have been developed for the ACPR:

- Check to see if there is already a document such as an Advance Directive that may have some useful information already gathered about needs and preferences
- Ask the person if they would you like to tell you what has happened to them in the past or if they would you prefer you to read their file
- Ask questions about what the person wants from you (some suggested questions are in Attachment A)

Recommendation VI: Using clinical judgement and timing to approach interactions and assessments

Different approaches are needed at different times in a person's journey with the service. If a person is in distress, the clinicians work will be very different than if the person is in a different space, such as when something quite specific is contributing to them needing to be involved with a mental health service. The most critical work of the clinician will be discovering what is happening and what will be most helpful to the person at that point in time.

Some suggestions for clinicians here are:

- If the person is in distress, use your clinical judgment to *sense if the person needs you to just sit quietly with them and not pressure them into talking or responding*. In the long term, this may create a space that helps people to connect with you rather than feel more distressed and pressured to answer what at times might feel like a barrage of questions. It may be as simple as just sitting or 'being with' the person, rather than 'doing for' the person in the very first instance.
- Maybe start with a question that is an 'ice breaker', not about mental health. It may be a question or comment about pets, the weather or any number of other things.
- Once it feels OK to begin with questions, let the person know you are there to support them, that there are some things you feel will be important to ask and that you also want to know what the person thinks is most important.
- Ask questions that address social and other domains of life (for example housing, employment, education, dual diagnosis, gender sensitivity etc.)

Recommendation VII: Prioritising what needs to happen from a consumer perspective

Asking the person to prioritise what needs to happen will give them a greater sense of control over their own lives as well as an increased sense of being understood, heard and having choices (all important for personal recovery).

Some suggested questions that may be helpful to determine consumer defined priorities are:

- Is there something you would like us to do for you right now?
- Are there any pressing matters that need to be addressed right now?
- What is the most important thing for you to focus on in your life at the moment/today?
- Note that revisiting this at each session or at frequent intervals may be useful.

Recommendation VIII – Include key partners in care wherever possible

It should be assumed that having others involved in a person's care is desirable unless otherwise expressed. The definition provided by the NWMH CCAG regarding 'key partners in care' reflected the 'nominated person' and is, *"The person I choose and who is willing and able to support me"*. Consultations confirmed that the nominated person and other 'key partners' will vary from person to person, may be different at different points in time (so it is important to check that the key partner hasn't changed) and that some people may not have anyone they consider able to be a key partner in their care/lives. The person/s may be a family member, friend or another person altogether. A key point to note is that the freedom to choose who your nominated person/s or key partner/s will be is very important. Although they may be different for each person, some notable points are that key partners in care will be someone you trust, a non judgmental person and someone who has empathy.

Examples of the process for including others are to ask:

- Has your Carer/Family member been informed of your current situation? Do you want them to be? How can I contact them?
- Is there anyone else you want to contact right now?

*Note – for fuller discussion on key partners in care, note Consumer Report Number – Key partners in Care: Engagement and Negotiation of Information.

5. Further issues for consideration

The recommendations from the consumer consultations and suggestions will need to be further developed and connected to the whole ACPR (i.e. the recommendations here will need to feed into operations, evaluation, and documentation and workforce components of the Redesign)

Attachment A – Suggested questions

Possible starting questions	
How can we be of help to you today?	How can we help? (with your trauma?) (Based on trauma informed approach)
Do you know why you are here today?	What do you call the problem?
How are you feeling at the moment?	What do you usually do about it? or, What usually helps?
What happened to you?	How can I/we/this place help?
What's causing you distress?	"Hi, my name is so and so, and I want to let you know I have read your Advance Directive. Let's take some time to go through it now together".

Some possible 'Prioritizing what needs to happen' questions:

Asking the person to prioritise what needs to happen will give them a greater sense of control over their own lives as well as an increased sense of being understood, heard and having choices (all important for personal recovery). The following questions may be helpful to determine consumer defined priorities:

- Is there something you would like us to do for you right now?
- Are there any pressing matters that need to be addressed right now?
- What is the most important thing for you to focus on in your life at the moment/today?

Creating a positive story/identity questions:

Focusing on strengths that make the person feel that they have something worthwhile to contribute is much more powerful than focusing on problems. Ask the person:

- What do you do well?
- What are your passions/interests/strengths?

For broader needs:

A possible introduction could be – "We are here to support you. There are some things that we feel will be important to ask you, but we want to know what is most important to you (i.e. questions that address social domains of life). Would you like to fill in this sheet/questionnaire or would you like me to ask you the questions?

Ask questions capturing the following domains:

(Format to be developed in conjunction with the documentation committee - Develop a tick box or Lickert Scale 1-5 or some other format)

Questions : For example, ask - Would you like to improve:	
Your housing situation?	Your relationships?
Your employment situation? Etc…	Your friendships?
Your education?	Your spiritual situation? Religion?
Your financial situation?	Your general health and wellbeing?
Your vocational situation?	Your medication practices?
Your transport situation?	Your drug and alcohol situation?
Your leisure situation?	Other? (still to be further developed)

Then ask:

- Which is the most important thing to support you with first? or
- Is it important to address any of these rights at the moment?

Key partners in care questions:

- Has your Carer/Family member been informed of your current situation?
- Do you want them to be?
- How can I contact them?

Other questions:

- After the first meeting, revisiting/reprioritising will be different for each person
- Set up with each person how often they want to revisit this initial needs questionnaire.
- For example, you may like to ask in the first or an early appointment:
- Would you like to start each session checking over this to see if things have changed or would you like me to check this again with you in 2, 3 6 months?
- Offer for the person to fill out the form or to answer the questions verbally
- At each subsequent appointment reevaluate and ask
- What is the most important thing to work on today?(note that it is good for clinician to reevaluate each time for themselves as well)
- Information needs to be recorded. Give copies to the person (and key partners)
- Be mindful that if talking to a person over the phone, they can hide things

Attachment B - List of consultations

Information gathered for this project from April 2012 – July 2012 came from:

VMIAC - Director, assistant director and information officer

Consumers in consumer workforce via the VMIAC Information officer email list

NWMH CCs

NWMH local CAGs

The VICSERV Conference

The VMIAC Consumer Workforce Conference

The Mary O'Hagan - Consumer Leadership Workshop

The National Recovery Forum key note presentations from Mike Slade and Ken Thompson

Attachment C – References

Department of Health. Framework for recovery-oriented practice. Victorian Government Department of Health, 2011.

O'Hagan M. A new story for a new leadership, *New Paradigm – Reframing mental health: A new state of mind. Australian Journal of Rehabilitation*, Autumn, 2012

Slade M. 100 ways to support recovery: a guide for mental health professionals. Rethink Recovery Series, vol. 1, 2009.

12.7 Carer report

1. Carer Perspectives on Identification of Carers and Their Needs

Information prepared by Jennifer Burger (Project Carer Consultant) in 2012 as a way to support clinicians to engage with carers/ families. It is about understanding the carer perspective within adult community teams.

Engagement and Information Sharing can be achieved by:

- identifying and capturing carer needs;
- identifying and engaging key partners in care;
- negotiating information sharing.

It also provides an explanation of the major findings and recommendations on what systems and processes will best achieve these outcomes. Specifically it contains:

- A description of the Carer Consultant tasks and how they relate to the overall ACPR framework;
- An outline of the methodology used to inform the recommendations;
- The main findings from consultations with carers leading to the proposed recommendations;
- Further issues for consideration or action;
- Appendices containing:
  Commonly identified needs of carers (Appendix A)
  Draft guidelines/questions from carers regarding clinicians' engagement of family/carers (Appendix B)
  List of people consulted (Appendix C)
  References (Appendix D)
  ACPR Framework Development Plan – front page (Appendix E).

The methodology used for the consultation and report preparation included a literature review; consultations with all North Western Mental Health (NWMH) carer groups including its Consumer Carer Advisory Group (CCAG); discussions with experts and key stakeholders; and data collection, collation and analysis.

2. Context

There are three key objectives within the Framework Development Plan for the ACPR. This Report outlines family and carer perspectives with respect to two of those objectives.

Objective 1 is to provide consistent evidence- based care to consumers and family/carers across NWMH In order to achieve this, strategies need to be put in place to ensure that:

- The provision of care is based on best available evidence and accepted standards;
- Processes that support responsiveness to consumer and family/carer needs and preferences through all parts of the journey;
- Staff are supported in the provision of evidence – based care through the delivery of appropriate training, mentoring and ongoing supervision;
- The delivery of appropriate staff training mentoring and ongoing supervision. The relevant key deliverables for the Carer Consultant were:
  - The identification of general domains of carers' needs and questions for clinicians to ask to identify the needs of each family/carer; and
  - The preferred method of family/carers on how and when this information can be collected.

Collection of information from family/carers was seen as crucial to the effective development of these strategies, particularly in relation to the following areas:

- The identification of commonly identified carer needs;
- Generation of questions for clinicians to ask to identify the needs of each family/carer; and
- Family/carer preferences for how and when this information can be collected.

Objective 2 of the Framework Development Plan is to provide seamless, appropriate and acceptable services to consumers and family/carers. In order to achieve this, systems and processes need to be developed to support appropriate and timely use of assessments, interventions and transfers of care, and to respond to consumer and family/carer needs and preferences throughout all parts of their journey. Again, in order to inform these developments, collection of information in relation to the following areas was needed from family/carer groups, including:

- A definition and recommended process for identifying "key partners in care";
- A family/carer definition of "engagement" and a list of key principles and activities which will promote it from their perspective;
- A recommended process from the family/carer perspective on how and when engagement should be negotiated; and
- A recommended process from the family/carer perspective for negotiating what information can be shared with care partners, when and under what circumstances.

The data collected and the recommendations which flow from them will inform the way NWMH will respond to the needs of family/carers and will reflect the key principles which underpin the ACPR.

3. Methodology

- A literature review was undertaken on carer needs identification, definitions of key partners in care, engagement of family/carers, confidentiality and information sharing;
- Initial consultation with a small group of NWMH Carer Consultants and carers to validate the findings from the literature search and seek consensus on the consultation document to be later used with all NWMH carer groups including its CCAG. The ACPR reporting template was introduced to them and discussed;
- Consultations were held with NWMH carer groups and its CCAG, and with external experts and key stakeholders, (refer to list of consultees in Appendix B); and
- The data from the combined groups' responses to Objectives 1&2 questions were collated, analysed and used as a basis for this report.

4. Findings and Recommendations

Recommendation 1:

Identify the family/carer of each consumer as early in the treatment and care process as possible

The family/carers consulted agreed that key partners in care should include the consumer; the family/nominated carer; relevant mental health service staff; General Practioners ; Psychosocial Disability and Rehabilitation Support Services (PDRSS) and other organisations, as appropriate, and that these key partners should be individually discussed with the consumer. However the focus of their discussions was on the family/carer as it was central to their concerns about being appropriately involved in the treatment and care of the consumer. They agreed on a number of ways that the service/clinicians could use to identify family /carers specific to each consumer, such as:

- Ask the consumer, when well, who should be involved if and when they become unwell. They noted that the family/carer is often estranged from the consumer during an illness episode because of the illness;
- Use advance directives;
- Ask carers to self-identify via handouts, posters and brochures in waiting rooms;
- Enter the contact details of the family/carer immediately on the Client Management Interface (CMI) and regularly update them
- Audit this data entry and develop Key Performance Indicators (KPIs) to monitor the process;
- Understand that the role and responsibility of the carer may change over time; and
- Be confident that if the consumer declines family involvement, the reason for it needs to be explored, and the question revisited at a later date. Be aware, too, that some information should then be given to the carer about what is happening and what they need to/can do in their caring role in the meantime.

Strong feelings were expressed across the carer groups about the need to seek NWMH clarification about a policy on contacting the family/carer if the consumer does not agree. The matter will be raised for discussion at the ACPR Executive Steering Committee and hopefully resolution will be reached across NWMH prior to implementation of the Redesign Project.

Recommendation 2:
Identify the specific needs of family/carers in the service

- Information regarding commonly identified carer needs was gathered from:
- The Mental Health Council of Australia (MHCA) national survey of the needs of carers of people with a mental illness (2009)
- A analysis of the needs of carers at North West Area Mental Health Service (NWAMHS) in 2009/10
- Consultations held across NWMH in July 2012 with North West, Inner West, Mid West carer support groups and with an expanded NWMH CCAG carer group covering all four services.
- There was strong and consistent agreement between carers with the commonly identified needs of carers gathered from the above research, and they are listed in detail in Appendix A and grouped under four major headings. Carers need to:
- Be identified and engaged by the service as partners in care;
- Be able to give, receive and share information which is accurately recorded and updated;
- Have their own needs assessed and appropriate service responses considered; and
- Have access to a recovery- oriented service which will provide the consumer and family/carer with the quality of care they need.

It is hoped that the above information will assist clinicians to understand commonly identified carer needs which they may want to consider when working with family/carers to assess and respond to their specific circumstances and needs. An agreed set of questions was required to assist them.

At NWAMHS, the CIIC had established a Working Group in 2011 to improve clinicians' engagement with family/carers and to draft guidelines and questions on this topic. Group members included clinicians, together with a Consumer and a Carer Consultant. The questions were organised into three time frames:

- At the first request to the service for help/triage/early after the consumer is registered with the service;
- During ongoing service provision; and
- Before the consumer transitions out of the service.

These draft guidelines were then presented for discussion at all the carer consultation sessions across NWMH. (Appendix B) and were unanimously endorsed and recommended for implementation in the new Framework for Care.

Recommendation 3:
Use a flexible approach to collecting this information

The family/carers consulted were asked about their preferences in how and when this information about individual family/carers' needs should be collected. They agreed unanimously that the service should have a flexible response to the approach used, depending on their circumstances and needs of the family/carer. Face to face contact whenever possible was preferred, but phone and letter were considered appropriate once a relationship has started to develop. Sometimes an initial phone call from the clinician to the carer may be helpful, to ask the carer how they wish to be contacted in the future. There was full agreement that information gathering is an ongoing rather than a linear process.

Five opportunities which offer optimal timing for collecting information were identified:

- When a carer requests help with a mental health problem before a client is actually registered – Triage or CATT to speak with the carer to clarify the situation and understand what is happening at that moment;
- With newly registered clients –clinician to phone carer initially to explain how the service works collaboratively with consumers and carers, and to make a time to meet together. Ask if the carer would prefer to meet alone with the clinician or with the consumer;
- With returning clients –ask the same questions as at initial assessment, ie What's been happening lately? What seemed to work after we last met, and what did not? What plans were made, and were you a part of them?;
- With ongoing clients –Maintain a good ongoing partnership with an open door between clinician and carer. When a consumer does not show for an appointment, the clinician could phone the carer to check if the consumer is unwell; and
- Before leaving the service, ie pre-discharge.

Recommendation 4:

Engage with family/carers as partners in care, as early in the treatment and care process as possible

The family/carers consulted were asked what they understood by the term "engagement". They agreed that, for them, "engagement" is the establishment of a relationship of trust and respect between the family/carer and the clinician, a working together, which cannot be rushed and which takes varying levels of time depending on the past experiences of families, their current concerns, and the patience and sensitivity of the clinician. Their understanding is based on the work of Grainne Fadden and Ian Falloon, as are the principles and activities to guide the clinicians' attitude to the family/carer that follow, and which were unanimously endorsed by those consulted.

Key principles and activities which should promote engagement from a family/carer perspective and guide the clinician's attitude to the family/carer:

- The clinician's attitude to the family is positive;
- The level of skill and expertise of the family/carer is recognised;
- The actions of the family/carer are seen as their best efforts to manage the situation within the limits of their resources;
- It is important to distinguish between the actions of a family/carer and their intentions;
- Every family/carer has its own culture;
- Family/carers should be welcomed, acknowledged, respected and supported as partners in care;
- Family/carers should be engaged as early as possible in the episode of treatment and care; and
- Information-sharing arrangements between consumers, carers and clinicians should be developed and reviewed regularly.

The family/carers consulted were then asked how and when they would like their engagement to be negotiated. There was unanimous agreement that the draft guidelines/questions developed by the NWAMHS Clinical Improvement and Innovation Committee (CIIC) Improving Clinicians' Engagement with Carers Working Group should be recommended for implementation to the NWMH ACPR Project. Three time periods were proposed and accepted:

- At the first request to the service for help, if possible, or early after the consumer is registered with the service;
- During ongoing service provision; and
- Before the consumer is discharged from the service.

Please refer to Appendix B for details.

Recommendation 5:

Increase communication between consumers, carers and clinicians about what information needs to be shared with whom and how, and when and why it should be done

NWMH family/carers consulted were invited to propose a recommended process for negotiating information sharing between consumers, carers and clinicians. They unanimously agreed to endorse the principles stated in the Position Statement on "Privacy, Confidentiality and Information Sharing" developed by the National Mental Health Consumer and Carer Forum (NMHCCF) 2011, and to recommend implementation of the key strategies and actions that arise from them, using a tri-partite approach, which means:

- Increased communication between consumers, carers and clinicians about what information needs to be shared with whom and how, and when and why it should be done;
- The development of workforce policies about information sharing with nominated carers
- The development of written agreements about information management;
- Ongoing staff education support and supervision on these issues;
- A review of ethical codes of mental health professionals to broaden their focus from maintaining consumer confidentiality to including appropriate information sharing with family/cares to enhance recovery; and
- The involvement of consumers and carers in the development of practical guidelines and the provision of training about information sharing.

Recommendation 6:
A generalised proposal to achieve the above specific recommendations:
Support all mental health professionals in NWMH to work with family/carers to maximise the recovery of the consumer and the outcomes for all

- This recommendation needs to be implemented by the provision of training, mentoring/ supervision for **all** staff, and
- Training, supervision and support provided to **some** mental health professionals in each AMHS to provide specialist evidence-based family interventions, such as BFT and MSG's.

5. Further Issues for Consideration

- Explore common ground between the consumer and carer perspectives on Objectives 1&2 issues, and identify differences or sticking points. The presentation of a combined voice, where possible, would be more powerful;
- Discuss further at the ACPR Executive Steering Committee, the issue of contacting family/carers with and without consumer consent so that a shared understanding can be reached across NWMH; and
- Seek advice from members of the ACPR Executive Steering Committee about ways to promote and advocate for acceptance of the consumer and carer recommendations for the ACPR, ie which working groups and committees and with which colleagues/ champions should we collaborate to achieve the above?

Conclusion

These recommendations should contribute to the desired culture change in the redesigned adult community mental health program and lead to the improvement of the clinical outcomes and the quality of experiences of our consumers and family/carers.

Appendix A:

Commonly identified carers needs (based on research findings listed in the text)

Carers need to:

1. *Be identified and engaged by the service as partners in care*

   Be welcomed, listened to and treated with compassion respect and understanding;

   Be identified at the first point of contact with the service, eg Triage or the initial request for help, and not necessarily wait for the consumer's registration with the service. The issue of consumer consent was considered very problematic in all three consultations and needs further discussion and consideration by the ACPR Executive; and

   Be engaged early by clinicians and have their expertise acknowledged and utilised

2. *Be able to give, receive and share information which is accurately recorded and updated*

   Be given timely information in plain language on a range of issues – illness, treatment options, alcohol and other drugs, when changes occur for the consumer, such as an inpatient admission, a change in medication or a treating professional, and prior to discharge;

   Have their contact details and other relevant information systematically entered and updated on CMI;

   To have a written information-sharing agreement with the consumer and clinician developed and reviewed regularly about issues related to their caring role This may include a wellness/relapse prevention plan, advance directive;

   Be given accommodation options by clinicians for consumers at all levels of care, especially if home is not an option; and

   Be given information about access to flexible respite options and given appropriate support for the consumer.

3. *Have their own needs assessed and appropriate service responses considered*

   Have their own physical and mental health needs assessed;

   Have their own financial needs understood;

   Have access to increased support and education to improve their ability to cope effectively in:

   - Dealing with grief;
   - Dealing with emotional difficulties and family dynamics related to illness in the family;
   - Safety in the home – bullying, threats, verbal and sometimes physical abuse;
   - Other relevant matters; and
   - Be provided with support systems, services and processes to help them become involved and participate in service development matters.

4. *Have access to a recovery-oriented service which will provide the consumer and family/carer with the quality of care they need*

   Feel confident that the consumer will receive integrated recovery-based care and will receive early intervention at each episode of care;

   See that acute care for the consumer is therapeutic and accessible;

   Have access to highly trained professional staff who will train the family (including the consumer) to work together by improving their communication and problem solving skills;

   Have staff who are trained in consumer and carer perspectives of living with mental illness and who understand the stigma, discrimination and isolation for both consumers and carers;

   Be given encouragement to provide feedback if the service is not working for them and to be given options; and

   Have confidence that Culturally and Linguistically Diverse (CALD) family/carers will receive a sensitive response from the service.

Appendix B:

NWAMHS CIIC Working Group Draft Guidelines to Improve Clinicians Engagement of Family/Carers

- Guidelines for clinicians to ask family/carers in the early stage of their involvement with the service
- An interpreter should be arranged in advance when required;
- Welcome the family/carers and thank them warmly for coming to the clinic to meet you; introduce yourself and ask them to do the same. Have your ID badge visible and give your name/ business card to them at the end of the meeting;
- Explain the reasons why you have invited them to meet with you;
- Tell them that you have already met with the client/their family member and:
- That you want to understand what has been happening for them in their family situation;
- Tell them about how the team in which you are employed works and about your role;
- explain that you have an information pack for them which you will discuss and give to them at the end of this meeting ;
- Give them the name of the Carer Consultants employed by the service and how they can assist families/carers;
- Explain that you want to explore how best to work together with a recovery focus;
- That this initial meeting is the beginning and it may take some time to develop trust and find the best ways; and
- Set up a follow up meeting/s, as appropriate.
- Ask the carer/family to tell you about what has been happening for them:
- A simple statement can be used to open the conversation and encourage those present to talk. For example, "It would help me if you could tell me about x– you know him/her best;
- When did you first begin to notice a change in him/her? What was different? What was happening then?;
- A genogram developed with the family's assistance might be helpful;
- Carers/family members may need to talk about what has been happening and may become distressed, they may need talk at length. Support them and engage with them. It is the beginning of a collaborative relationship;
- Ask them about their own physical and mental health and wellbeing; and
- Make sure that adequate time has been set aside so that the family/carers do not feel that the meeting is rushed.

Introduce the idea of confidentiality:

- Always explain the value of openness and transparency;
- Then say, "You have given us a lot of information. Is there anything we have talked about that you would prefer x not to know at the moment?;
- Explain that x may also wish to keep some matters private and that you will respect his views as much as possible too;
- Assure them that your goal is to work collaboratively towards open discussion and that your preference is to meet together with [name of consumer] and them whenever possible or practicable;
- Tell them it is important for them to know where everyone fits in with confidentiality. Explain that as a clinician, you can provide them as carers with any information they reasonably require for their caring role, but add that it will work much better if [name of consumer] agrees to it. Introduce the possibility of a written information sharing agreement;
- Let them know about the limitations to our confidentiality. People's safety is paramount. If there are concerns about safety for [name of consumer] or for you, we would have to let other people know of the risk; and
- Encourage family/carers to seek information and attend relevant educational programs.

Guidelines for clinicians to ask consumers in the early stage of engagement

Can you tell us about your living arrangements at the moment? Is there anyone else you would say is an important part of your life?

Who are the people supporting you at the moment?

Can you tell me why you have chosen them?

In what way are they involved with you?

Does s/he know what is going on for you right now?

Who is the person you most rely on at the moment?

Who would you like to nominate for us to contact

We would like to invite x to meet with us in the next couple of weeks so that we can understand how best to work together

Our service understands that families/carers often have concerns and worries about treatment and sometimes don't know who to talk to about them. We have found it helpful for families if we arrange a time to meet, introduce ourselves and listen to their questions. So we will be contacting [insert person's name]

Is there anything we have talked about today that you would prefer to keep private at the moment? We will respect your right to privacy and confidentiality.

Our goal is to work together towards open discussion and our preference is to meet with [insert persons name] whenever possible or practicable.

There are certain general issues about your treatment and care that we will need to speak with your family/carer now, and we will work together to sort out other matters and how we might do that.

It is important that you, as a clinician speak gently but firmly telling them what will happen, not asking, and that our service is committed to collaborative practice which means working with the whole family/carer to achieve better outcomes for all.

The carers stressed once again the incredible importance of "how" these questions are asked by the clinicians.

Guidelines for clinicians engaging carers – ongoing

The following questions are suggested:

Would it help you if we had an interpreter?

What do you need help with right now?

What information would help?

Let's review the information sharing agreement we made earlier

How did you come to be [insert person's name] carer?

What other options was there for his/her care?

Do you get on well with [insert person's name]?

Does it change when [insert person's name] is unwell?

What do you understand about [insert person's name] illness?

What effect has this had on you, and on the others involved?

How do you talk with [insert person's name]?

How do you deal with [insert person's name] when things are difficult?

What kind of supports do you have?

How are you managing at home?

Are there any financial issues you are facing? How have you been coping?

Do you feel safe at home?

Do you sometimes feel frightened? Of what?

Are there any accommodation issues at the moment?

Do you and your family feel you are on a roller coaster?

Are you aware that this service offers Building Family Skills Together/ other family programs?

It was noted that staff should use their clinical judgment and select which questions are relevant to the current situation. They should be seen as suggestions rather than a script.

Guidelines for clinicians engaging carers at family meetings prior to the consumer leaving the service

NB If there is no family meeting a phone call should be made to the carer prior to transition out of NWMH care:

Do you have any concerns about [insert person's name] leaving the community mental health service? Could you tell me about them?

Where do you understand X is going to live on discharge?

Are you taking him/her home? What arrangements and supports have been made?

Do you feel comfortable about coping with [insert person's name] at home after s/he leaves hospital?

Do you have all the information you need?

Has [insert person's name] current medication been explained to you? [If not, an explanation of the current treatment regime may be required including type of medications, frequency and whether the medication is oral or by injection, who will be prescribing the medication now that the consumer is moving; potential side effects, expected duration of treatment].

Have you been given a written treatment plan? If not, we will give you one and explain it

What have you noticed about [insert person's name] behaviour when s/he becomes unwell? We can explain these early warning signs, if you would like and help you understand what you can do?

Do you know how to contact the service if you need to?

[Provide phone numbers as required]

Do you know which doctor will be looking after [insert person's name] with his/her mental health issues once he/she leaves here?

Would you like some information on how we/other organisations can support you in your caring role?

Are there any questions you have for us?

Is there anything else you want to tell us?

Attachment C: List of People Consulted

All 7 x NWMH Carer Consultants

Carer Consultant Network Victoria members – 15

Victorian Mental Health Carers Network – Exec. Direc.

Jackie Crowe- BHS Carer Consultant

IW Family Working Group

Gillian Scaduto – Peer Support Worker ARAFEMI/NAMHS

Dr Margaret Leggatt

Dr Carol Harvey

Kirsty Irving, Evaluation and Service Coordinator (ESIC) NWAMHS

NWAMHS CAG carers– Estelle Malseed; Christina Makrides

NWAMHS Carer support group - 10 people

IWAMHS Carer Support Group - 7 people

NWMH CCAG – Carer group

NWMH expanded Carer Group - 15 people

NWMH Consumer and Carer Consultants together

MWAMHS Carer Support Group - 19 people

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ATTACHMENT GB-3

This is the attachment marked 'GB-3' referred to in the witness statement of Gail Bradley dated 26 June 2019.

Accommodation history and continuity of care in patients with psychosis

Alex C.N. Holmes, Mark A. Hodge, Gail Bradley, Alan Bluhm, Jane Hodges, Louisa Didio, Natasha Markulev

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Objectives: The objective of this study was to determine the relationship between accommodation history and management outcome in patients with psychosis.

Method: Demographic information, diagnosis and an accommodation history were taken from patients with psychosis accepted for case management by the Inner West Area Mental Health Service over a 12-month period. The patients were followed up 2 years later to determine their continuity of care and discharge outcome.

Results: One hundred 42 patients completed the assessments. Forty-eight percent of patients had spent at least 1 day in a homeless setting in the previous 12 months. Twenty-two percent of patients had long-term (between 2 and 12 months) and six percent chronic (more than 12 months) homelessness. The duration of previous homelessness was significantly inversely correlated with the length of engagement with the service, continuity of psychiatric care at discharge or likelihood of transfer to primary care. Previous interstate mobility was significantly associated with discontinuity of care at discharge.

Conclusions: A history of homelessness is common in patients with psychosis using inner urban mental health services and is associated with poorer engagement with psychiatric services.

Key words: chronicity, homelessness, outcome, psychosis.

Australian and New Zealand Journal of Psychiatry 2005; 39:175–179

Homeless individuals move in and out of homelessness and between various homeless settings [1]. The homeless population on any one night in Australia is about 100 000 [2]. The number of individuals moving through homeless settings in 1 year is many times greater. The importance of elucidating these movements or 'temporal patterns' has been clearly articulated: 'Only when we understand the dynamics of exits and re-entries into homelessness will we be able to successfully intervene and prevent recurrences' [3]. This is especially true for homeless persons with mental illness where duration, stability and mobility have direct relevance to the level of disability, engagement with services and effective treatment.

It is not easy to maintain contact with homeless persons over time, making longitudinal studies difficult. Retrospective accommodation histories, although limited by the accuracy of recall, are the most practical way of collecting information on the temporal patterns of accommodation use. Chamberlain [4] found that 30–40% of a population of youth homeless were homeless for less 2 weeks, and 15–25% for more than a year. The 2001 Australian census, using data on persons staying in Supported Accommodation Assistance Program (SAAP) facilities, estimated that 60–70% of homeless persons

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Alex C.N. Holmes, Senior Lecturer (Correspondence)

Department of Psychiatry, Royal Melbourne Hospital, University of Melbourne, c/o post office, The Royal Melbourne Hospital, Parkville, Melbourne, Victoria 3050, Australia. Email: acnh@unimelb.edu.au

Gail Bradley, Clinical Psychologist; Alan Bluhm, Clinical Assistant; Jane Hodges, Social Worker; Louisa Didio, Nurse; Natasha Markulev, Nurse

Waratah Area Homeless Psychiatric Service, Inner West Area Mental Health Service, Melbourne, Australia

Received 20 February 2004; revised 29 October 2004; accepted 3 November 2004.

remain so for at least 6 months [2]. The census was unable to provide any temporal data on shelterless persons, people using private boarding houses or staying temporarily with friends.

Research into the patterns of accommodation use in homeless people with mental illness is not well developed. Early descriptive studies, such as that by Fischer and Breakey [5] defined subgroups of the ‘situationally homeless’ and the ‘chronically mentally ill street people’, the former being seen as entering the homeless sector for a short time after a change in circumstances and the latter being long-term homeless. Arce [6] interviewed patients attending an adult emergency shelter for 2 months and categorized them into three groups with increasing durations of homelessness: those in acute crisis, episodic homeless and habitual street people. In his cohort, age, past psychiatric hospitalization, prevalence of psychotic symptoms, and need for treatment all increased with the duration of homelessness.

Persons with psychosis make up between 18% and 29% of the homeless population [7,8]. Managing homeless persons with mental illness repeatedly reinforces the importance of accommodation type, mobility and stability in determining outcome. Despite this observation, no research had been conducted on the patterns of accommodation use in patients with mental illness and how these relate to management outcome. Our aim was to study the relationship between pattern of accommodation use in patients with psychosis managed by an inner city mental health service and its relationship with management outcome. We expected that a history of accommodation instability and mobility or a history of homelessness would be associated with decreased length of engagement with mental health services and discontinuity of care at discharge.

Method

Setting

The study was conducted in the Inner West Area Mental Health Service (IWAMHS). The IWAMHS is a public psychiatric service covering the central business district and inner northern suburbs of Melbourne, Australia, comprising a population of approximately 173 000 persons [9]. The service includes a continuing care team, a crisis assessment team, a mobile support team, a homeless team and an inpatient unit.

Sample and data collection

The study population included all patients with psychosis accepted to the IWAMHS for case management during the 2001 calendar year. Referrals were received from other area mental heath services, primary care settings, homeless services, or following crisis assessment and were accepted for case management if the patient was resident in the catchment area and not adequately engaged and managed by primary care or private psychiatric services. Patients were eligible for entry to the study if they were aged 18 or greater, had adequate English language skills, were able to give consent and had a primary diagnosis of a psychotic illness. Data was collected during the initial psychiatric assessment, with use of the patient record and collateral history. Discharge information was collected at the end of the 2003 by reference to the patient’s record and an electronic database of mental health service patient contacts.

Measures

The psychiatric diagnosis was reached after clinical assessment by a psychiatry trainee or consultant psychiatrist using the DSM-V categorical system [10]. Data was collected for each accommodation used during the 12 months prior to assessment, and included the type of accommodation, the duration it was used, and its geographical location. This data was used to place the patient in categories of homelessness (type, chronicity) and provide measures of accommodation mobility and stability.

The categories of accommodation type recorded incorporated the system of primary, secondary and tertiary homelessness used in the Australian Census [1] and mapped to those used in the low prevalence component of the National Study of Mental Health and Wellbeing [11]. Primary homelessness included sleeping shelterless, in a car or in a ‘squat’. Secondary homelessness described people using emergency accommodation, temporarily staying with friends or relatives. Tertiary homelessness referred to the use of boarding houses, caravans, motels or rooming houses. The categories for chronicity were determined in reference to previous literature [4,6,12]. They were based on the total time spent in homeless settings, which may have involved one or more discontinuous episodes. Short-term homelessness was defined as up to 2 months, long-term homelessness as more than 2 but less than 12 months and chronic homelessness as more than 12 months. Mobility was calculated by summing the time spent in each geographical category. The categories available were inner urban, outer urban, rural, interstate and international and defined in reference to the location at the time of assessment. For example, time spent interstate in a rural setting was recorded as interstate. Stability was measured by counting the number of different accommodations used in the 12-month period.

Discharge information was collected for all patients as of 31 December 2003. The date of discharge, reason for discharge, continuity with psychiatric follow up, the type of follow-up psychiatric service and discharge to primary care was recorded for patients discharged from the service. For those patients still managed by the IWAMHS their length of contact was calculated to the discharge assessment date and they were assumed to have maintained continuity of care with a public psychiatric service. Continuity was seen to have occurred when there was a planned transfer of care to an appropriate follow up service which had engaged and accepted the patient.

Analysis

Patient accommodation information was entered into a spreadsheet. The sum of days in each type of accommodation and geographical location was calculated for each patient. The time spent shelterless, in emergency accommodation and single room accommodation was summed and used to place the patient in temporal categories of non-homeless, short-term homeless, long-term homeless or chronic homeless.

Statistical analysis was conducted using the SPSS statistical package [13]. Chi squared analysis was used to determine the categorical differences between homeless groups. A two tailed t-test was used to determine differences in parametric measures between homeless and non-homeless populations and ANOVA for parametric measures between the four categories of homelessness. A Pearson correlation was used to determine the relationship between duration of homelessness and duration of engagement.

Results

Study population

There were 198 new patients with a primary diagnosis of psychosis taken on for management by the IWAMHS during the study period. One hundred 43 of these patients were recruited. The sample comprised 99 males, mean age 35.4 years, and 44 females mean age of 45.3 years. Ninety four patients were recruited from the continuing care team and 49 patients through the homeless team. There was no statistical difference between recruited and non-recruited patients in terms of age or gender.

Diagnoses

One hundred and five patients had a diagnosis of schizophrenia; 19 had schizoaffective disorder, 16 had bipolar disorder with manic illness and three delusional disorder. Bipolar illness was present in only three patients with a history of homelessness, which was significantly less than those without a history of homelessness ($p = 0.018$).

Homelessness

Fifty-six patients (39%) were homeless at the time of assessment. Seventy patients (49%) had spent at least 1 day in a homeless setting during the 12 months prior to assessment. Of patients with a history of homelessness, 41% had short-term homelessness (less than 2 months), 46% had long-term homelessness (more than 2 but less than 12 months) and 13% chronic homelessness (greater than 12). Looking at the population as whole, 23 percent of the previous 12 months had been spent in a homeless setting.

Accommodation type

The percentage of time spent in each accommodation type used during 12 months prior to assessment, stratified by category of homelessness, is summarized in Fig. 1. Subjects with a history of homelessness spent significantly more days on average shelterless (40.7 *vs* 0, $p = 0.000$), in crisis accommodation (31.9 *vs* 0, $p = 0.000$), single room accommodation (58.3 *vs* 0, $p = 0.000$), hostels (53.7 *vs* 18.3, $p = 0.019$) and as a psychiatric inpatient (9.5 *vs* 2.2, $p = 0.000$).

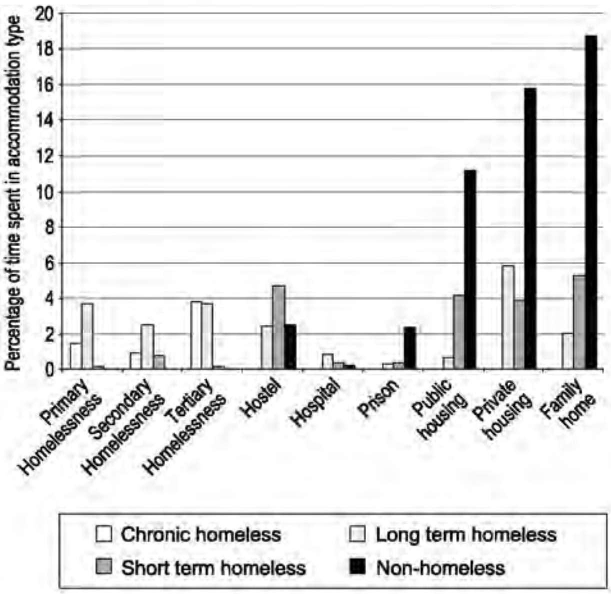

Figure 1. Percentage of time spent in each type of accommodation over previous 12 months, according to category of homelessness (n = 143)

Accommodation stability

The population as a whole had on average 2.8 accommodation settings in the past year. Subjects with a history of homelessness had a significantly greater mean number of accommodations (4.1 *vs* 1.8, $p = 0.000$) than those without a history of homelessness. The number of accommodations was lowest for the-non-homeless (mean = 1.8) and highest for the long-term homeless (mean = 4.5), with short-term and chronic having on average 3.8 and 3.6 episodes of accommodation per year, respectively. Stability was not significantly different between temporal categories of homelessness.

Accommodation mobility

Subjects with a history of homelessness spent significantly more days on average in rural areas (24.6 *vs* 0, $p = 0.016$) and interstate (81.3 *vs* 4.9, $p = 0.000$), and significantly less days in outer urban settings (88.8 *vs* 151.9, $p = 0.016$) during previous 12 months.

Discharge outcome

Patients with a history of homelessness had a shorter duration of engagement with the service as compared with patients with no history of homelessness (385 days *vs* 535 days, $p = 0.016$). The duration of contact with the service was inversely correlated with the duration of homelessness in the past 12 months ($r = -0.292$, $p = 0.001$). This association was replicated in the temporal categories, where in the duration of engagement decreased between short-term, long-term and chronic homeless groups. The duration of contact was also inversely correlated with time in the inner urban ($r = -0.31$, $p = 0.001$) and interstate settings ($r = -0.37$, $p = 0.001$) and with stability ($r = 0.188$, $p = -0.037$).

Patients with a history of homelessness were more likely to experience a discontinuity of care at discharge (29% *vs* 10%, $p < 0.01$). Interstate mobility was higher in those patients with discontinuity at discharge (Mean days interstate = 126 *vs* 16, $p < 0.01$). Homeless patients were more likely to be discharged to a public psychiatric service than patients without a history of homelessness (74% *vs* 57%, $p < 0.05$) and less likely to be discharged to primary care (17% *vs* 38%, $p < 0.05$).

Discussion

This study describes the association between accommodation history in patients with psychosis and treatment outcome. The findings support long articulated notions about the relationship between homelessness, accommodation instability, mobility and difficulty maintaining continuity of care. The study also provides an insight into the dynamic nature of homelessness and provides baseline information about accommodation type, mobility and stability in patients with psychosis accessing in inner city public mental health service.

The outcome of an episode of care with the mental health service was significantly affected by the pattern of accommodation use during the previous 12 months. The length of homelessness inversely predicted the duration of contact with the service. This was not an unexpected finding given the relationship between homelessness and accommodation instability. There was also a higher incidence of discontinuity of care and a decreased likelihood of discharge to primary care in patients with a history of homelessness. This finding has significance for the long-term management of these patients suggesting that they are at risk of becoming stuck in cycles of engagement and disengagement within the public psychiatric system.

There was significant accommodation instability in patients with psychosis. Movement occurred in and out of homelessness. Patients with a history of homelessness only spent 36% of the previous year in homeless settings. The remainder of the time was spent in the full range of accommodation types, including rental properties and the family home. Movement also occurred between different homelessness settings. This movement presents both a challenge and an opportunity for mental health services. On one hand regular changes of accommodation makes engagement and follow up more difficult. On the other hand movement through crisis accommodation services provides an opportunity for detection and referral.

Shelterlessness is the most severe end of the homeless spectrum. Shelterlessness is associated with poor access to community supports [14] and an increased risk of physical ill health and nonaccidental injury [15]. In our sample, 5% of the time in the past 12 months was spent shelterless. This figure is 250 times higher than the point prevalence of shelterlessness in the general population of inner urban Melbourne, measured at 0.02% [2]. Our figures equate to eight patients having spent an entire year on the streets, or approximately 25% of the shelterless population. In fact 26 different patients had had an episode of shelterlessness in the year prior to assessment. This finding goes against the notion that shelterless persons with psychosis are ‘street people’, at least in inner urban Melbourne. Rather, patients spend a variable time on the streets, from a few days to many months.

Homeless persons in the study group were more mobile when compared with the non-homeless group. Twenty-nine percent of patients with a history of homelessness had been interstate in the previous 12 months. Time spent interstate correlates strongly with discontinuity at discharge. None of the patients with a history of interstate travel were discharged to primary care. Clinical experience of working with homeless patients is that interstate travel often occurs with little planning. Travel may be as a part of a long standing pattern, in response to a breakdown in accommodation or an attempt to avoid psychiatric services. Currently management of these patients occurs in an ad hoc manner. There may be a role for a more co-ordinated national approach to this group of high mobility patients involving the identification of a centralized point of contact for interstate services seeking patient information and the flagging of high mobility patients.

The strength of this study relates to the use of an accommodation history to provide measures of accommodation use, mobility and stability over time and its application to a patient population moving through an inner city mental health service. The calculation of these parameters required the novel use of spreadsheet, database and statistical software which once developed has been easy to apply to new populations. The use of a dynamic population allowed for a greater representation of patients with unstable accommodation histories and a history of homelessness providing enough power for the analysis of the relationships between these parameters and discharge outcomes.

The study may be criticised with regards to the population used. The study was not a cross sectional prevalence survey. A cross sectional survey would have included a greater representation of stable long-term clinic patients, and fewer patients with a history of homelessness. At any one time the service population as a whole will be more stable, less mobile and more adequately housed than the population that is moving through the service. Certain patients were not included in the study, including patients managed in primary care, private psychiatry or not engaged with services.

The measures used in the study are open to challenge. The reliability of a 12 month accommodation history in patients with psychosis is not known. Those patients who gave an inconsistent or unconvincing history were excluded, but the details of the history are unlikely to be fully accurate, especially in cases with significant accommodation instability. The psychiatric diagnosis was based on clinical assessment, rather than by semi-structured interview. Finally, the outcome measures related to service use rather than symptoms levels or measures of disability.

Conclusion

Patients managed by the IWAMHS have a wide range of accommodation profiles. Some experience of homelessness is common and is a predictor of future management discontinuity. The homeless are not nearly as 'hidden' as is presumed. Furthermore, the notion of a 'homeless population' as a stable disparate group of individuals is inaccurate and may inhibit service development. For mental health services to best engage and manage patients with psychosis they need have knowledge of their patient's temporal patterns of accommodation and be aware that homelessness adversely affects management outcome.

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ATTACHMENT GB-4

This is the attachment marked 'GB-4' referred to in the witness statement of Gail Bradley dated 26 June 2019.

COMMUNITY PSYCHIATRY

The need for the development and evaluation of preventive psychosocial forensic interventions in mainstream adult community mental health services

John Gleeson, Pamela Nathan and Gail Bradley

Objective: *This paper provides a selective review of forensic research with the aim of making recommendations for the development and evaluation of psychosocial interventions for the mainstream community mental health setting to address the needs of patients with a history of offending.*

Conclusion: *Mainstream community mental health services can be guided by existing findings in the design of psychosocial intervention and prevention programmes. There is growing need to develop and evaluate such interventions.*

Key words: *community mental health, dangerousness, forensic psychiatry, psychosocial interventions.*

The relationship between severe mental illness and risk of criminal convictions, and violence more specifically, is an important field of investigation because of the enormous human and financial costs to the victim, the perpetrator and the broader community. In addition, violence perpetrated by mentally ill consumers potentially erodes public support for improving services to people with serious mental illness.[1] There is, however, a relative paucity of evidence-based research in the area of risk assessment and treatment of consumers in the mainstream community mental health setting. This paper reviews recent findings regarding the rates of offending in the adult mental health population and research into the pathways of patients into forensic institutions from mainstream mental health settings. Evidence-based research which has evaluated the effectiveness of psychosocial interventions within forensic and correctional settings was also selectively reviewed, with the aim of developing specific recommendations for the development and evaluation of psychosocial interventions for patients with histories of criminal convictions in the mainstream community mental health setting.

Recent evidence indicates a steady increase in the proportion of consumers of adult mental health services who have a history of criminal convictions including violence. For example, a recent Victorian case linkage study, which examined the criminal records of four cohorts of first-admission patients, showed that the rate of criminal convictions associated with the diagnosis of schizophrenia increased from approximately 15% to 25% of patients between 1975 and 2000.[2] Furthermore, anecdotal evidence suggests that forensic institutions are increasingly making referrals to community mental health settings.[3] It is likely that this trend will

John Gleeson

Associate Professor, Department of Psychology, The University of Melbourne and Northwestern Mental Health Service, Melbourne, Vic., Australia.

Pamela Nathan

Area Senior Psychologist, Inner West Area Mental Health Service, Royal Melbourne Hospital, Melbourne, Vic., Australia.

Gail Bradley

Psychology Advisor, Northwestern Mental Health Program, Melbourne Health, Royal Melbourne Hospital, Melbourne, Vic., Australia.

Correspondence: John Gleeson, Department of Psychology, The University of Melbourne, Level 7, 14-20 Blackwood Street, North Melbourne, Vic. 3031, Australia.
Email: jgleeson@unimelb.edu.au

doi: 10.1111/j.1440-1665.2006.02278.x

Australasian Psychiatry (2006)

increase over time. Within the Victorian context, for example, it is probable that as the court system sentences increasing numbers of psychiatric offenders to the local specialist forensic services,[4] there will be an increase in discharges to the mainstream community mental health system. Trends in the availability in Australia and New Zealand of more potent forms of illicit substances, such as methamphetamines[5] (which has been associated with problems with controlling aggression in patients with psychosis[6]), may pose a further related challenge for community mental health services. Collectively, these factors may have significant flow-on effects for mental health triage, increasing the need for cooperation between mainstream community mental health and forensic services, and building further upon the impetus to develop adequate systems of tracking and managing the risks of consumers of community mental health services with serious mental health and forensic issues.

Of course, in highlighting this area of unmet need, it is important to avoid alarmist falsehoods regarding the aetiological link between offending and mental illness. The reported increases in conviction rates among Victorian public mental health consumers are consistent with increases reported in other follow-up studies conducted before and after the era of deinstitutionalization.[1] Wallace *et al.* highlighted that the increase in convictions within the mentally ill population in Victoria is proportionate to the increase in convictions in the wider population.[7,8] This is consistent with evidence that schizophrenia (the best researched serious mental illness in relation to risk for violence) directly accounts for only a small proportion (estimated at about 10%) of violent crime within the community.[7,9,10] Others have concluded that the increase in the proportion of consumers with offences can most likely be accounted for by an increase in the rates of substance abuse and dependence, especially when co-occurring with antisocial personality disorder,[11] perhaps in addition to other factors including homelessness among young men with serious psychiatric problems.[12] However, debate apparently continues as to whether the most violent crimes, such as murder, can be fully accounted for by comorbid dependency problems.[13,14]

THE IMPLICATIONS FOR COMMUNITY MENTAL HEALTH

Leaving aside the causes of the increase in the rate of convictions among registered psychiatric patients, the trend highlights significant challenges for policymakers, researchers and mental health and welfare services in identifying and responding to the specific needs of this population, their carers and the community. In addition, important preventive opportunities in relation to criminal offending and mental illness now prevail.

First, there are challenges for consumers with forensic issues who leave forensic institutions or prisons for the community (frequently crisis accommodation services), where life stressors, in the absence of appropriate supports in combination with access to substances, may lead to recidivism and deterioration in mental health.[12] These consumers are often stigmatized in the wider community[15] and possibly by mental health clinicians, who may be frightened or horrified by the heinous or perverse nature of some crimes. These consumers may require programmes which facilitate their adjustment and reduce their suffering (and thereby their re-offending). Mental health clinicians may require corollary programmes to sensitize them to the problems these consumers face, including the aetiology of their offences, and the possibilities of offence reenactments. Unfortunately, such programmes have very rarely been developed or evaluated internationally,[16,17] and some, including intensive case management, have not always proven to be effective in reducing rates of violence compared with standard care.[18] For patients and their families, there is also often an absence of adequate resources which could stabilize many of the underlying problems which can contribute to a criminogenic lifestyle, especially appropriate levels of supported accommodation programmes or services geared for the homeless.[19,20] In short, there is a critical need to accumulate further evidence to guide the development of appropriate and efficacious psychosocial interventions in the mainstream community mental health setting for this growing subgroup of consumers.[21]

Second, there are challenges posed for community mental health services in terms of providing safe care for both consumers and staff. Critically, this increased demand is occurring in the absence of specific forensic expertise in the workplace or available evidence-based risk-prevention interventions and secure facilities.[3] In the absence of a coherent, evidence-based and adequately resourced model of intervention, community mental health staff may experience fear, low morale and danger in the workplace.[22]

Some researchers have attempted to address gaps in knowledge regarding the clinical pathways of consumers who offend. A recent multi-site study across four countries matched a group of patients diagnosed with schizophrenia who were treated through forensic services with a group treated through general psychiatric hospitals. The findings demonstrated that 24% of patients who were treated solely within the general psychiatric system had a criminal record; importantly 78% of those who were eventually treated within a forensic service were initially treated within a general psychiatric hospital and, of those, 40% had a criminal history preceding their initial admission to a general psychiatric hospital.[21,23] This study highlights the potential for preventing the pro-

Australasian Psychiatry (2006)

gression to more serious offences if effective risk assessment programmes and treatment interventions can be designed and evaluated for the mainstream adult mental health context. Factors which were predictive of a criminal history before the initial admission included behavioural problems during childhood, substance misuse before the age of 18 years, alcohol dependence and a comorbid diagnosis of antisocial personality disorder.[21]

In a study including the same cohort of patients, when antisocial personality problems were controlled for, severe positive symptoms of psychosis and so-called 'threat' and 'control over-ride' symptoms were associated with a risk of violence over a 12 month follow-up period in patients diagnosed with schizophrenia.[14] This is consistent with findings from research into the development of specific actuarial risk assessment tools specific for the mainstream community mental health setting which have been applied to both formal forensic patients and patients with a history of offending to inform risk management.[24] However, as some reviewers have noted, there are differences between patient groups in forensic and mainstream mental health services, for example, in the overall rates and history of offending, which may limit applicability of existing actuarial tools.[25] Notwithstanding these limitations, it is unfortunate that many mental health clinicians have not received evidence-based training in these tools or in forensic risk assessment or had the clinical experience of forensic clinicians.[26] Similarly, it is our experience that many clinicians in mainstream mental health are unfamiliar with relevant clinical outcome research from the forensic context relating to problems such as anger, psychopathy and related criminogenic factors.

SOME POTENTIAL GUIDING PRINCIPLES FOR DEVELOPING PSYCHOSOCIAL INTERVENTIONS

Of course, many of the potential approaches to these issues are likely to be found in the policy sphere, in better overall resources for community mental health services, and in improved protocols between the mental health and justice systems.[22] However, one component of the solution, firmly within the domain of community mental health services, is also likely to be the development and evaluation of appropriate psychosocial forensic interventions. While there is much data regarding the efficacy of pharmacological interventions for acute agitation,[27] there is little consensus or research data from well-designed trials of specific psychosocial interventions for reducing or preventing the risk for re-offending or in optimizing clinical and functional outcomes for patients with a history of criminal offences which could be delivered safely and economically within mainstream community mental health settings. This includes outcome studies which evaluate programmes to manage the transition of forensic patients into the community,[12,16] and specific therapeutic interventions within mainstream services for patients including patients with anger and adjustment problems,[28] which Szmukler has recently argued should be the initial research priority for mainstream mental health services.[3] Although psychosocial interventions exist in continuing care programmes in community mental health services, specific focus needs to be given to psychosocial precipitants of offending, such as poverty, domestic violence, homelessness, substance usage and so on. The interaction between these stressors and offending may shape appropriate psychosocial forensic interventions. To date, little has been documented at all about the nature of treatments received in community mental health settings by consumers with serious mental illness who engage in violent behaviour,[1] and even fewer evaluation outcome studies have been reported.[29]

The challenge in designing interventions is, of course, that they would need to be flexible enough to cater for a broad range of clinical and forensic issues presenting in a heterogeneous group. For example, Hodgins has recently highlighted that there are at least two subgroups – those with a history of offending which precedes the onset of serious mental illness and those whose offences were committed post-onset of illness.[1] Effective interventions are therefore likely to be multifaceted, address a range of clinical and forensic issues, based upon idiographic formulations, and even gender-specific.[28] Treatment outcome may also be moderated by legal status and motivation for engagement, which differ as patients move from forensic to mainstream community mental health settings.

Prospective follow-up studies of recidivism in consumers with severe mental illness provide a useful starting point in informing guiding principles for psychosocial interventions.[30] This research has employed actuarial statistics, such as iterative classification tree approaches and receiver operator characteristics analysis[24] in order to identify predictive factors of re-offending, based upon data from standardized risk assessment instruments.

Findings can help guide the selection of assessment tools and sensitize clinicians to the importance of matching interventions to distinct and varied factors associated with violence. For example, Skeem *et al.* recently utilized the actuarial approach to validate three distinct clusters of consumers who are at increased risk of re-offending – alpha, beta and delta.[31] The alpha group was described as the primary psychopathic group who was the most violent and who held core psychopathic traits of callousness and emotional detachment. The beta group was prone to emotionally driven violence in the context of prominent borderline personality traits and perceived stress; substance abuse, not surprisingly, was found to be a significant problem in this group. The delta group, who often had lengthy histories of intensive psychiatric treatment, was found to commit violent acts primarily in the context of active psychotic symptoms. Given the emerging evidence base[32] for psychological therapies for treatment-resistant psychosis, it could be argued that the delta group is a logical priority for the development and evaluation of specific preventive interventions. While there is a paucity of research on the alpha and beta group in the community, it could also be argued that interventions for these groups could be timely to develop because they represent an increasing number of dangerous clients who present at mainstream services and who do not fulfil the treatment criteria of forensic facilities.

In designing appropriate psychotherapeutic interventions, the identification of subgroups of mentally ill consumers at risk of re-offending can be combined with a well-established literature regarding factors associated with successful correctional programmes for reducing recidivism.[33–36] Research has consistently highlighted that four principles underlie successful programmes. These include first an adherence to a focus upon so-called *criminogenic needs* which entail aspects of individuals' lives which are conducive to, or supportive of, offence acts including antisocial activities, antisocial attitudes and substance abuse. These are conceptualized as dynamic and malleable risk factors which, when reduced, ameliorate the risk of recidivism. Of course, in mental health settings, significant progress has been made in interventions for comorbid substance abuse,[37] but significant pessimism arguably needs to be addressed in relation to antisocial personality traits, despite recent reviews which have concluded that therapeutic nihilism is not supported empirically, and that both cognitive behavioural therapy and insight-orientated psychotherapies have shown promise, albeit in less than ideally designed trials.[38,39] The second identified principle has been the matching of style and modes of interventions to the learning styles of offenders.[40] The principle seems particularly pertinent to severe and enduring psychotic disorders where the idiographic assessment of well-known neuropsychological problems[41] could significantly enhance the tailoring of psychoeducation regarding anger and violence.

The third principle is that the level of intensity of prevention programmes should be matched to the identified risk level of the offender and programmes may need to address the offence-related and offence-specific issues of offending.[40] However, in order to execute this principle, sustainable training and supervision programmes in both appropriately validated actuarial tools and in clinical risk assessment and treatment need to be more widely disseminated among community mental health clinicians. The responsivity principle highlights that the most effective interventions are those that are based upon modelling, graduated practice, rehearsal, role playing, reinforcement and detailed verbal guidance and explanations, including cognitive restructuring. These skills are of course well established among many mental health clinicians who are trained in cognitive behavioural therapy.

Fourth, a prime therapeutic task may be to ascertain what specific needs are met by offending, including power and control, affiliation needs, esteem needs, social needs and so on.[42] Recent intervention programmes in correctional settings assist clients in reframing their needs to achieve 'the good life' but not a crimogenic life.[43] Major components of these programmes can include problem-solving, self-management, education of values and social interaction training, because most offending occurs in an interpersonal setting.[44]

Finally, we recommend the adoption of a comprehensive and flexible treatment programme containing a range of strategies, in individual and group formats, targeting specific clinical and forensic factors, and which is tailored to clients with specific forensic issues and diagnoses. It may be possible to target subcategories of clients in accordance with typologies of re-offending risk in keeping with the research by Skeem *et al.*[31] Their classifications gave emphasis to the nature of violence as the key distinguishing feature of each group and they stressed that diagnosis may overlap. For clients who have been diagnosed with antisocial traits or psychopathy, core components of a treatment programme may include victim empathy, problem-solving, conflict resolution, anger identification, provocation management, and so on. These clients are most likely to commit serious crimes of violence against the person, for example assault. The major treatment goals for those who have borderline traits or personality may include stress inoculation, problem solution, social competency, emotional regulation, and so on. These clients are most likely to commit income-generating crimes against property to support substance usage or minor assault or property damage in the context of interpersonal distress. The major treatment goals for the psychiatric patients who have been diagnosed with active psychotic symptoms may include intensive symptom control of command hallucinations, management of perceptions of threat, and so on. These clients may commit violent crimes against people.

The components of the treatment programme can be used by each subtype of patient and can be group or individual. Each of these client subcategories may need intensive case management and corollary attention can be given to the psychosocial aspects of their lives which may contribute to a criminogenic lifestyle. We also think it is important to situate these treatment interventions in a conceptual framework which emphasizes the positive, life-giving, healthy potential, and relationships of these clients in keeping with the treatment interventions which promote the 'good life' attitudes and perspectives on offenders and the mentally unwell.[43] As Skeem *et al.* noted, while these patients may not always comply with traditional treatment programmes, the existence of specific programmes may at the very least sensitize health practitioners to the treatment needs of these patients.[31] The task for community mental health professionals is to develop clinical treatment programmes which address the specific forensic needs of psychiatric patients who are being treated in a community rather than a forensic setting. Of course, in order to achieve this, the skills and knowledge of practitioners will need to be extended, and some modifications to existing interventions designed in the forensic setting may be required, such as integration with assertive outreach and case management models.[45] Any innovations would need to be evaluated within well-controlled studies. Finally, as illustrated by the international emergence of dual diagnosis treatments, additional resources and new collaborations will be required to develop, evaluate and sustain innovative and evidence-based approaches to a growing unmet need.[46]

CONCLUSION

In order to develop appropriate systems, training, assessment and treatment, and preventive programmes, more fine-grained prospective follow-up research regarding the forensic, clinical and psychosocial needs of consumers treated within mainstream mental health system, who have a history of offences, is required. Further, data is needed regarding the nature, intensity and effectiveness of interventions currently provided to these consumers within mainstream community mental health. Subcategories of clients may be identified according to their psychological and offence characteristics and tailored psychosocial interventions developed accordingly. Evidence-based research is necessary to validate the usefulness of programmes which are designed to meet the specific needs of psychiatric forensic clients and potential forensic patients. Unique and vital opportunities exist in community mental health to utilize existing psychosocial interventions in an intensive and specialist context, allowing the extension and development of existing resources and skills. The unmet needs of these consumers, the risks of recidivism and the dangers of the workplace are compelling, and require urgent attention from mental health practitioners, service providers and policy-makers.

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Royal Commission into
Victoria's Mental Health System

ATTACHMENT GB-6

This is the attachment marked 'GB-6' referred to in the witness statement of Gail Bradley dated 26 June 2019.

Working towards Recovery with Evidence-Based Interventions

"Make a difference every time... every opportunity ...."

Our Identity

The Inner West AMHS is committed to working with consumers during their recovery by offering holistic and evidence-based treatment aligned with their values, which is inclusive of family/carers and provided by clinicians with well-developed skills.

Our Commitment

- To build and maintain a program based on evidence-based interventions, informed by lived experience, for mental health conditions
- To provide training and learning opportunities through various modalities including the IW Practice Development Calendar, peer consultation, coaching and supervision as well as external training opportunities.
- To support staff to acquire and maintain a high degree of skill in a range of evidence-based treatments

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Core and Specific Evidence Based Interventions

Psychological Interventions	Family and Carer Work	Health & Wellbeing	Vocation	Lived Experience	Overcoming Hurdles
Early Warning Signs & RWP discussion (within 3/12) CBT Fundamentals*	Family Contact (within 6/52)	Physical Health Form (within 3/12, repeated annually)	Conversation about Vocation APQ6 (within 3/12, repeated annually)	Conversation about Peer Support options	LSI-R:SV Screen SUBA
CBT for Psychosis (CBTp) Acceptance & Commitment Therapy (ACT) Therapies for Borderline Personality Disorder CBT for co-morbid Anxiety & Depression Be Well Live Well - Early Warning Signs Relapse Prevention Program	Single Session Family Consultation Multiple Family Group Family Therapy FaPMI Programs	Assisted Intensive Medication Service (AIMS) Medication Alliance Health Promotion & Education Wellness Activities	Vocational OT Assessments & Interventions Action Over Inertia The Works	Peer Zone Peer-led Recovery Groups Peer Support Family/Carer Peer Support	Risk Management Planning Risk Reduction Treatment D2 Motivational interviewing QUIT Program Harm minimisation Relapse prevention Eating Disorder CBTe

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GB-7

This is the attachment marked 'GB-7' referred to in the witness statement of Gail Bradley dated 26 June 2019.

Transforming mental health services for delivery of evidence-based psychosocial treatment:
What works in supporting practice change?

Gail Bradley – Area Manager/Clinical Psychologist

Inner West Area Mental Health Service

NorthWestern Mental Health

Key issues for community mental health practice

- Increased morbidity from physical health problems (2-4 times higher rates of smoking*, drug and alcohol use, poor nutrition, sedentary lifestyle, side effects of medications)
- Life expectancy 10-32 years lower than general population
- Risk of suicide associated with decreased quality of life, hopelessness and disempowerment
- High rates of incarceration and representation in prison populations
- Decreased workforce participation and consequent poverty (16-24%) cf 75%*
- Restricted social networks and social exclusion
- Family/carer stress and burden

- Ruther, Bobes, de Hert, Svensson, Mahri, Batra et al., 2014

NorthWestern Mental Health

Drivers for service reform

- International concerns about community mental health practice (clinical guidelines, http://mentalhealthpartnerships.com/resource/the-abandoned-illness-a-report-by-the-schizophrenia-commission/)
- Service delivery at IW had narrowed to medical treatments, multiple assessments, case management
- Limited efficacy of standard case management

  (Marshall et al Cochrane Review)*
- Minimal use of known effective psychosocial evidence-based treatments for severe mental illness as per clinical guidelines
  - Psychological therapies (CBTp, activity scheduling, personalised psychoed, EWS etc)
  - Family interventions (SSFC, MFG's..)
  - Peer led recovery (IPS, PeerZone)
  - Medication adherence programs, metabolic monitoring
  - Approaches for specific conditions e.g. BPD, Eating Disorders)

Implementation challenges

- *"One of the most critical issues in mental health services research is the gap between what is known about effective treatment and what is provided to and experienced by consumers in routine care in community practice settings"**
- New interventions estimated to "languish" for 15–20 years

* Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation Research in Mental Health Services: an Emerging Science with Conceptual, Methodological, and Training challenges. *Administration and Policy in Mental Health*, *36*(1), 10.1007/s10488-008-0197-4. http://doi.org/10.1007/s10488-008-0197-4

NICE article

(National Institute for Health Care Excellence)

Barriers to practice change

- Lack of awareness and knowledge re evidence based practice
- Motivation (internal factors very important)
- Acceptance and beliefs – perceptions of benefits, views of peers, disbelieving the evidence, belief in ability to adopt new behaviour
- Skills – training, skill practice opportunities, support from peers
- Practicalities – lack of resources (importance of manageable caseloads)

- https://www.nice.org.uk/media/default/about/what-we-do/into-practice/support-for-service-improvement-and-audit/how-to-change-practice-barriers-to-change.pdf

Community Redesign

- Community redesign across NorthWestern Mental Health July 2013 – integration of community functions to reduce silos, multiple assessments, transition risks
- Structural change was also the **catalyst** for practice change
- Change was required to enable uptake of evidence based interventions – caseload changed from 38+ per CM to 15-17 per KC
- Commenced practice change February 2014 with introduction of practice domains, and educational supports
- Now about a half way through what we thought would be a 5-year change project

Our mantra

"Make a difference, every time, every opportunity"

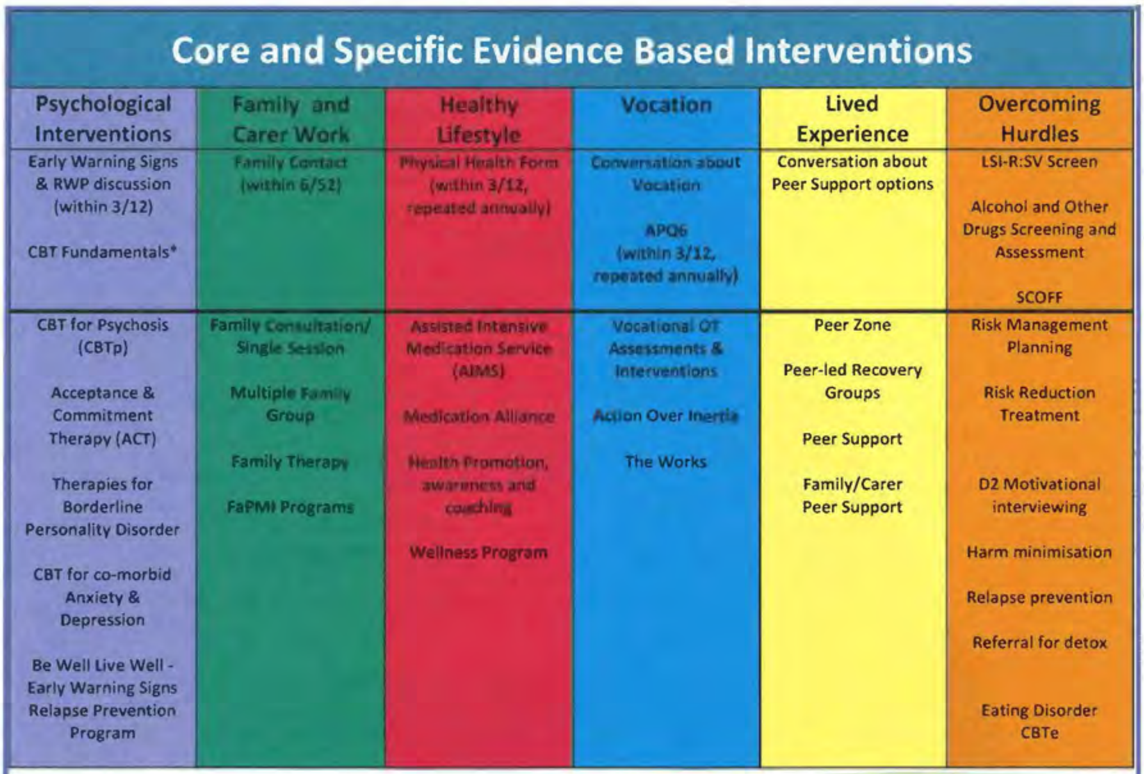
Multi-pronged reform strategy "aligning culture with vision"*

- Consistent leadership
- Change to professional development approach (hardwiring supportive culture)
- Role and workforce strategies – getting the right people and implementation roles
- Developed monitoring platform to improve reliability
- Accountability interventions – program level and individual

*Reliability methodology from Advisory Board

IW practice change plan Evolution of Practice Domains Vision and Changes to Professional Support Structure

Our Strategy	
Practice Domains Core and Specific Interventions	NWMH Practice Guide, developed by senior clinicians across the service Meetings professional seniors and DCS Leadership group collaboration
Recruited Practice Development Manager 0.6 EFT	Professional development calendar, orientation program, supports practice leads and program managers, ACT lead

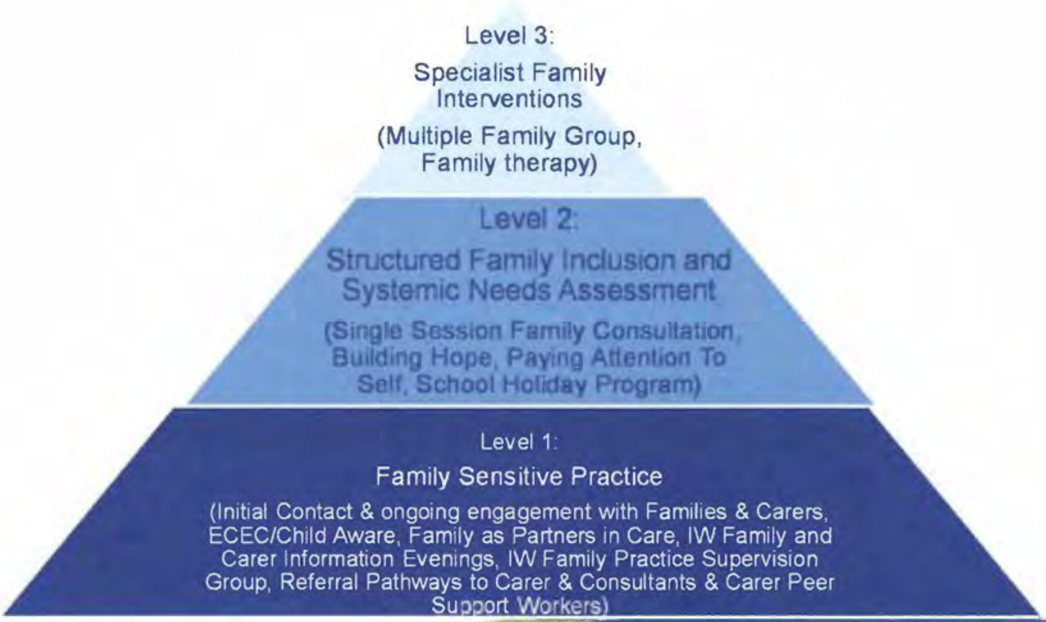


Core and Specific Evidence Based Interventions

Psychological Interventions	Family and Carer Work	Healthy Lifestyle	Vocation	Lived Experience	Overcoming Hurdles
Early Warning Signs & RWP discussion (within 3/12) CBT Fundamentals*	Family Contact (within 6/52)	Physical Health Form (within 3/12, repeated annually)	Conversation about Vocation APQ6 (within 3/12, repeated annually)	Conversation about Peer Support options	LSI-R:SV Screen Alcohol and Other Drugs Screening and Assessment SCOFF
CBT for Psychosis (CBTp) Acceptance & Commitment Therapy (ACT) Therapies for Borderline Personality Disorder CBT for co-morbid Anxiety & Depression Be Well Live Well - Early Warning Signs Relapse Prevention Program	Family Consultation/ Single Session Multiple Family Group Family Therapy FaPMI Programs	Assisted Intensive Medication Service (AIMS) Medication Alliance Health Promotion, awareness and coaching Wellness Program	Vocational OT Assessments & Interventions Action Over Inertia The Works	Peer Zone Peer-led Recovery Groups Peer Support Family/Carer Peer Support	Risk Management Planning Risk Reduction Treatment D2 Motivational interviewing Harm minimisation Relapse prevention Referral for detox Eating Disorder CBTe

IWAMHS Pyramid of Family Inclusive Practice

Adapted from Mottaghipour and Bickerton, 2005



Level 3:

Specialist Family Interventions

(Multiple Family Group, Family therapy)

Level 2:

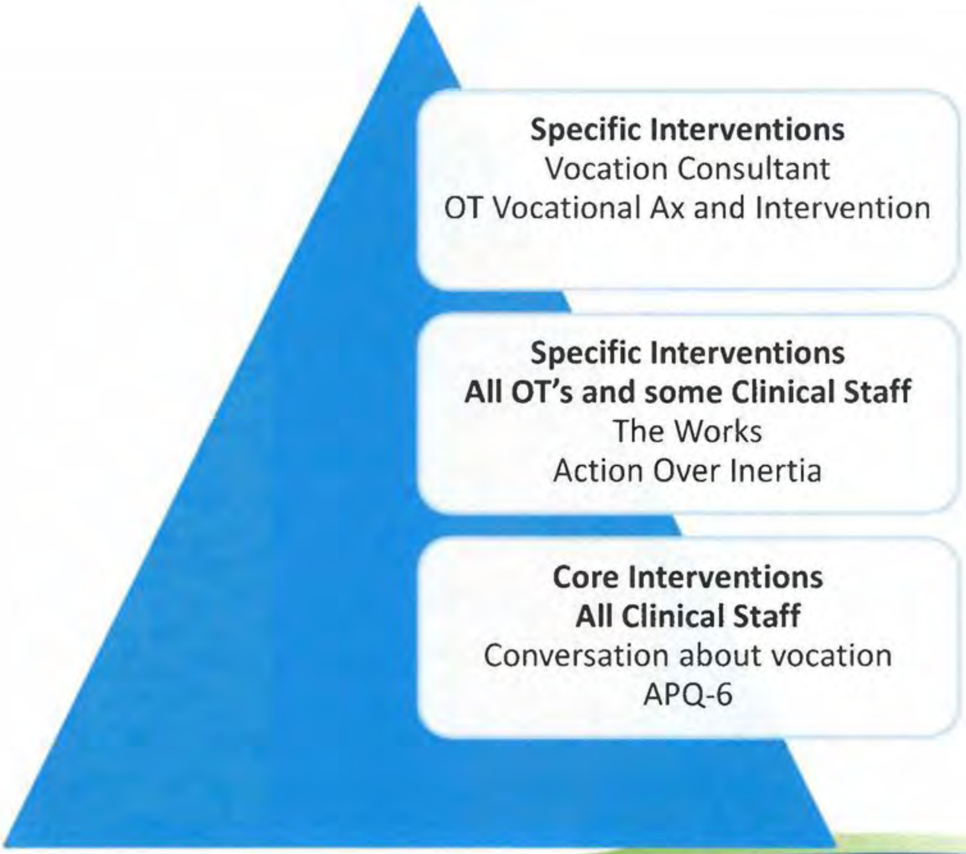
Structured Family Inclusion and Systemic Needs Assessment

(Single Session Family Consultation, Building Hope, Paying Attention To Self, School Holiday Program)

Level 1:

Family Sensitive Practice

(Initial Contact & ongoing engagement with Families & Carers, ECEC/Child Aware, Family as Partners in Care, IW Family and Carer Information Evenings, IW Family Practice Supervision Group, Referral Pathways to Carer & Consultants & Carer Peer Support Workers)



Specific Interventions

Vocation Consultant

OT Vocational Ax and Intervention

Specific Interventions

All OT's and some Clinical Staff

The Works

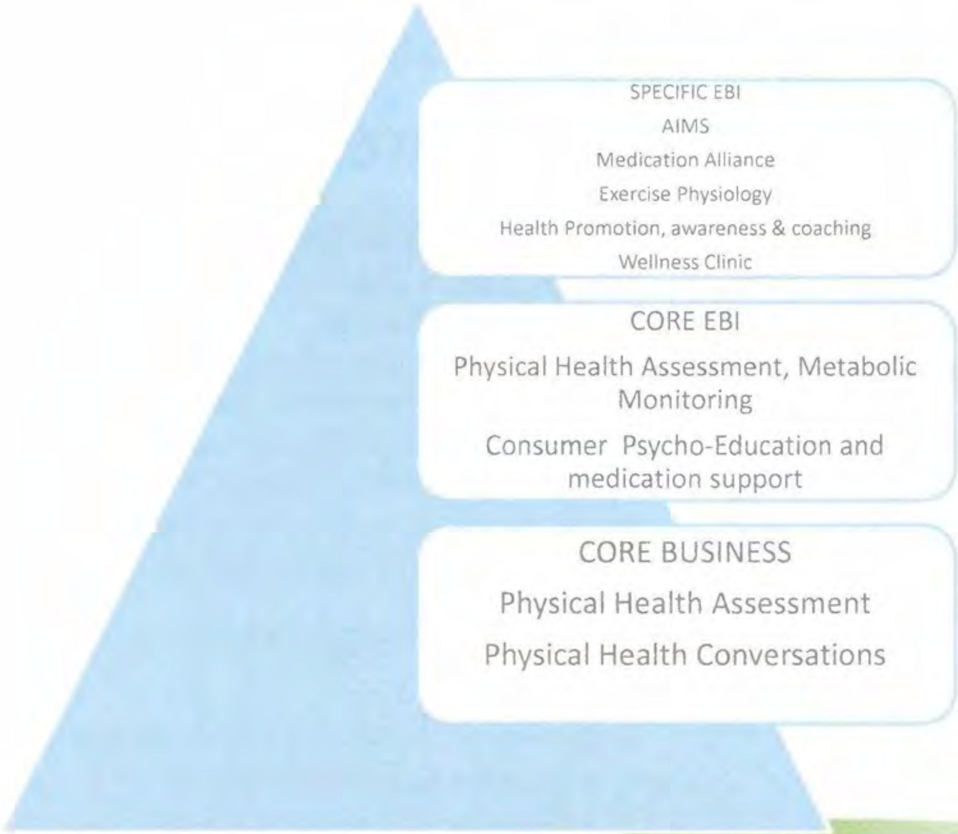
Action Over Inertia

Core Interventions

All Clinical Staff

Conversation about vocation

APQ-6



SPECIFIC EBI

AIMS

Medication Alliance

Exercise Physiology

Health Promotion, awareness & coaching

Wellness Clinic

CORE EBI

Physical Health Assessment, Metabolic Monitoring

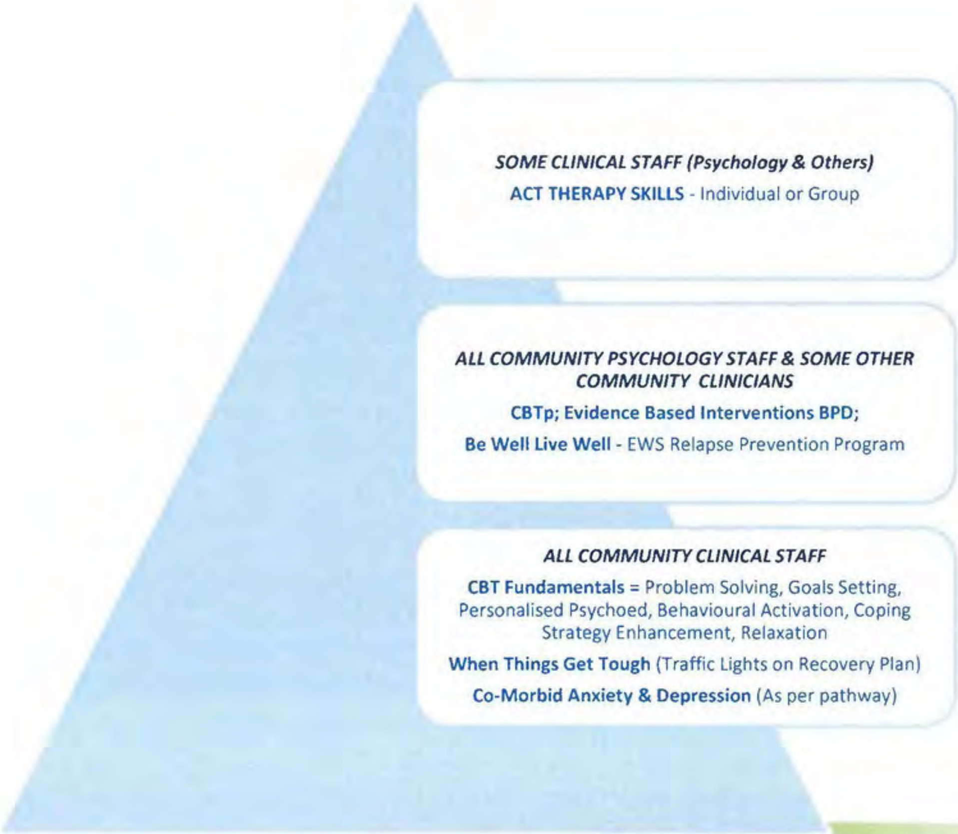
Consumer Psycho-Education and medication support

CORE BUSINESS

Physical Health Assessment

Physical Health Conversations

NorthWestern Mental Health



SOME CLINICAL STAFF (Psychology & Others)

ACT THERAPY SKILLS - Individual or Group

ALL COMMUNITY PSYCHOLOGY STAFF & SOME OTHER COMMUNITY CLINICIANS

CBTp; Evidence Based Interventions BPD;

Be Well Live Well - EWS Relapse Prevention Program

ALL COMMUNITY CLINICAL STAFF

CBT Fundamentals = Problem Solving, Goals Setting, Personalised Psychoed, Behavioural Activation, Coping Strategy Enhancement, Relaxation

When Things Get Tough (Traffic Lights on Recovery Plan)

Co-Morbid Anxiety & Depression (As per pathway)

NorthWestern Mental Health

Changes to professional support structures

Strengthened professional/discipline seniors roles	Evolved "Practice Lead" roles from conventional discipline senior roles - Articulated the range of ***core interventions*** and any associated measures within 6 practice domains to occur during the initial engagement period - Developed the range of ***specific interventions*** within each domain that could be offered and delivered to consumers and carers by any discipline subsequent to core intervention. - Rotate quarterly rotation through program clinical review meetings
Area of Practice Reps	Engagement of RPN4's and AHP3's as team level champions per practice domain "Voice" during clinical review meetings suggesting interventions Each practice domain has a set of competencies articulated for clinicians

Area of Practice	Team 1	Team 2	Team 3	CCU
Psychological Interventions	Jacqui Fischer Michelle Eastwood	Alicia Reilly Simone Cremona Deb Osborne Lisa Bloom Megan Harrison	Amanda Kenny Clare Allan Stephanie Mertins Sheran Kay	Lisa Bloom
Family Work	Trevor Carlisle Amal Ibrahim Leah Tylee	Jo Searle Jackie Pearce Alison Lewis Paul Hawkins Hannah Bloom	Nicole Sydenham Jason Webb Phyllis Chan Tess Shannon	Sharyn Clarke
Healthy Lifestyles	Natasha Markulev	Angela Cole Amelia O'Reilly Kerryn Devenish	Tony Blanco Julie Lee	Niki Fourniotis
Activity and Vocation	Erin Rees	Joe Judge Ryan Fomiatti Johnathan Smith	Dev Raithanththa	Natasha Tudor Kirsty Grieg
Lived Experience				
Dual Diagnosis	Trevor Carlisle Jacqui Fischer Michelle Nuttall	Karnen Arnott	Charlene Nation Stephanie Mertins Nicole Sydenham	Sharyn Clarke Adrian Cullen
Forensic				

Embedded learning supports

Strategy	Change and investment in continuous professional development
Orientation program for new staff	Runs 4 x year Developing IW you tube training channel
Regular professional development calendar focussed on practice domains	Fortnightly, session repeated within fortnight at different time to capture all staff
Monthly peer supervision groups with contracted visiting recognised expert facilitators	Acceptance and Commitment Therapy – Dr. Eric Morris Adobe Acrobat Document Cognitive Behaviour Therapy for psychosis (CBTp) – Prof John Farhall Family Work – Brendan O'Hanlon - Bouverie Family Therapy Centre
New "in house" supervision groups, workshop formats to develop "advanced practitioner" level training	D2 – Nathan Hall and Rick Yeatman Personality disorders – Margaret Foulds Forensic work – Catherine Dwyer
"Pearls of Wisdom"	Five minute info-bites from domain leaders in staff meetings
Monthly clinical showcase sessions	Consultant psychiatrist chairs identified Focus is use of evidence-based practice
Live modelling	Joint appointment with a practice lead who demonstrates the intervention in vivo

IW practice change plan Role/workforce strategies

Strategy	
Title change	"Case manager" to "Key Clinician"
Update all position descriptions with expectations re use of EB interventions	All contain a statement at front of PD stating organisation expectation re evidence based practice. Practice domains poster included in all PD's as appendix

Invest and recruit to specific novel roles with functions to support and promote practice domain. Build the practice domain team.	• Employment consultant
	  • Employment readiness
	  • Conjoint job seeking
	  • Individual placement support model (strong EB)
	• Physical health
	  • Nurse practitioner candidate
	  • Exercise physiologist
	  • Physical health EN's
	• Be Well Live Well coordinator (relapse prevention program)

Broad program delivery impacts

- Unanticipated benefits of workforce development
- Cohort of practitioners with shared interests
- Expansion of program beyond individual service delivery to group programs
- Social and participation benefits for consumers

Workforce continued

- Recruit specific skill base so we employ people who are already motivated to deliver the required interventions
- Blended roles (0.3 specific/0.7 key clinician)
    - Eating disorders clinicians x 2
    - AoD clinicians x 3
    - Justice liaison position (works across prison and AMHS)
- Expectation all staff have an identified area of expertise and will participate in additional training – articulated in their learning plan

Snapshot Employment

- Initial survey
  - 12% employment rates (Full and PT) our service vs 18-20% similar services internationally
- Individual Placement Support model
- Post Employment consultant outcomes
- 206 referrals in 18 months
- 30 consumers in paid employment, 20 in voluntary or training programs
- Many considering employment who would not have without the "initial conversation" or meeting with Candice

Activity, participation and vocation practice lead Rachel and Employment Specialist Candice

Program domain delivery impact

Activity, Participation and Vocation

- The Works – pre-employment 6 week group program co-facilitated with peer worker
- Conversations about vocation total = 348
- Activity over inertia interventions (gp and ind)
- Pathways to Participation RCT across NWMH (combined Works and AOI group program)
- CREATE Art program
  - experience as a working artist
  - sales of work at exhibition
  - catering work experience

Create 2

Thomas Miller - recipient of the Create 2 Best Emerging Artist for 2017 Award.

IW practice change plan
Role/workforce strategies (cont)

Physical Health Domain

- Physical health nurse practitioner
- Physical health enrolled nurse
- Exercise physiologist
    - Assessments
    - Direct exercise training 1:1
    - Linkage with community gyms
    - Health coaching (advice)
    - Secondary consults with clinicians

Program domain delivery impact
Physical Health

- Walking group 2/week
- Swim/gym 1/week
- 228 physical health assessments completed total (103 new/125 reg)
- Wellness Clinic (weekly dietetics/diabetes and monthly education group)
- Health promotion activities (hearing, dental, cancer screening etc)
- Breathe Easy QUIT program
- GP linkages
- Concurrent staff wellbeing program (run club, Pilates etc)

Some of the physical health practice reps

Program domain delivery impact

Family work

Family work and carer practice reps

- New Multiple Family Group each year (I year duration)
- "Graduates" MFG group - continuous
- Building Hope program Eating Disorders Unit
- New Eating Disorders MFG commencing soon
- Single session family consultations (102 recorded to end March)
- FAPMI programs - School Holiday program - 4 per year, CHAMPS (peer support and psychoed primary school age children) (4 day program), Space4Us (peer support and psychoed high school age kids)

Carer Peer Support

Commenced 2014 with recruitment of
Carer Peer Support Coordinator

- CPSW's have unique qualities and are trained in Single Session Carer Peer Work Model.
- They provide:
  - Support and information to carers/families and provide a safe space to ventilate
  - tell their story,
  - make sense of/process their caring experience
  - connect with someone who understands the experience
- Identify the sort of information/support carers may be lacking or do not understand and guide them as to who is best placed to provide this.eg Information sharing, navigating the system and rights and responsibilities.

Carer Peer Support

- Facilitate linkages for carer within the organization and wider community
- Facilitate collaboration between the clinic consumer and family/carers
  - Listen and connect with carer/ family through lived experience and peer support principles
- "Thank you so much, talking with you has made a huge difference to how I am feeling. I feel like I have some choices and direction now."

Program domain delivery impact Consumer lived experience

Consumer peer team:
Jen, Donna, Marty, Darby and Krystyn

- Peer facilitated groups on the IPU
  - How do I stay out of here
  - Know your rights
- Individual support to write Advance Statements
- Consumer educators providing recovery series for nursing students
- PeerZone workshops in the community
- Post discharge peer support (IPS model)

What is PeerZone?

PeerZone facilitators Marty and Donna with PZ founder Mary O'Hagan

- PeerZone is a series of peer-led workshops in mental health and addiction, where people explore recovery and whole of life wellbeing
- PeerZone workshops are facilitated by two peer workers who have a lived experience of mental distress
- There are 15 workshops:
    - Leading our Recovery
    - Exploring our Stories
    - Understanding our Distress
    - Understanding Addictive Behaviour
    - Coping with Stress
    - Understanding Trauma
    - Minding our Lifestyles
    - Enhancing our Relationships
    - Finding our Voices
    - Empowering Ourselves in MH Services
    - Dealing with Crisis
    - Maximising our Income
    - Finding and Keeping Work
    - Finding and Keeping a Home

Participants' feedback

- *'Rewarding.'*
- *'Glad I came.'*
- *'Lots of positive ideas and energy.'*
- *'Very supportive and a great debrief.'*
- *'I like the music and songs. They keep me relaxed.'*
- *'Was good to share ideas and experiences with others going through similar life experiences. Made me feel like I'm not alone.'*
- *'PeerZone is helping me lift from being stuck in mental distress.'*
- *'PeerZone is more beneficial than any counselling that I've done.'*

PeerZone
Shared learning for wellbeing

NorthWestern Mental Health

Program domain delivery impact Psychological interventions

- Wise Choices program is aimed at consumers who would benefit from learning skills to
  - manage difficult thoughts and emotions; and
  - increase their engagement with meaningful activities
    - (10 weeks) (3 times/year), 1st cohort completed
- Be Well Live Well Relapse Prevention program
  - Feasibility program ethics completed
  - Therapists identified
  - Program commenced

Increased accountability
Program Level

Leader accountability – quarterly performance meetings with each team manager and consultant psychiatrists – area manager and clinical director	Review the monthly core and specific interventions data in the meeting (live data)
Changed format of Clinical Quality Meeting (attended by Lead consultants, practice leads and managers)	Each program Lead Consultant reports on the activities within the program against the domains. Includes - a self-rating (below standard, room for improvement, going well) - Evidence - Future actions

IW practice change plan
Increased Accountability – Program level
Developed evaluation and monitoring strategy

1. Core interventions

Monitored via clinical review meetings – to be completed within first six weeks of contact (family contact) or by initial wellness and recovery review (3 months)

Monthly presentation of data at staff meeting

Monitoring of **CORE interventions**

-APQ6 (conversation about activity, participation and vocation)

-Physical Health assessment screening

-Family contact in first 6 weeks

-Single Session Family Consultation in first 3 months

-CBT fundamentals

IW practice change plan
Increased Accountability – Program level
Specific interventions

2. Enhanced monitoring of **specific interventions (**contacts dashboard)
Entered via contact data in a research field
- Mouse mats
- Drop down boxes for electronic entry

SPECIFIC INTERVENTIONS CONTACT CODES

Enter code in **Research Field 2**

Psychological Interventions

PA
FN
BD
CP
CT
AC
EW

Physical Health

HP
PI
PR

Lived Experience : Peer Support

PZ Peer Zone
P1
P2
P3

ENGAGE

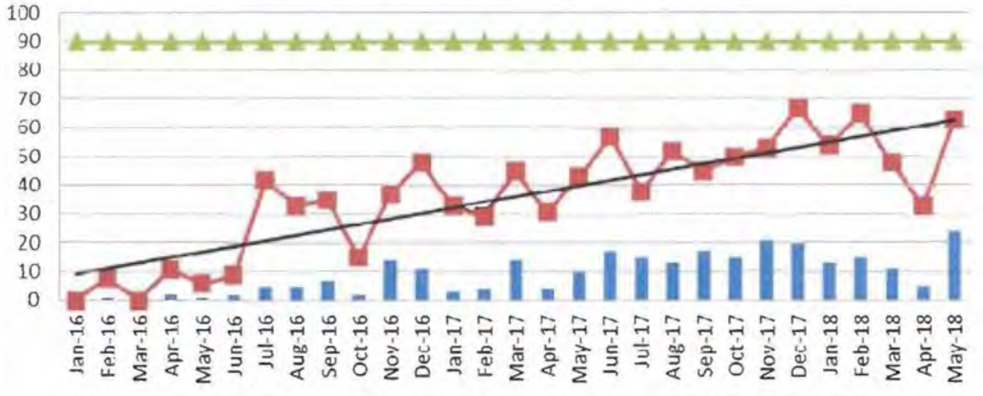
EP
ES
ED
EH
EC
EO

IW practice change plan
Increased accountability - individuals

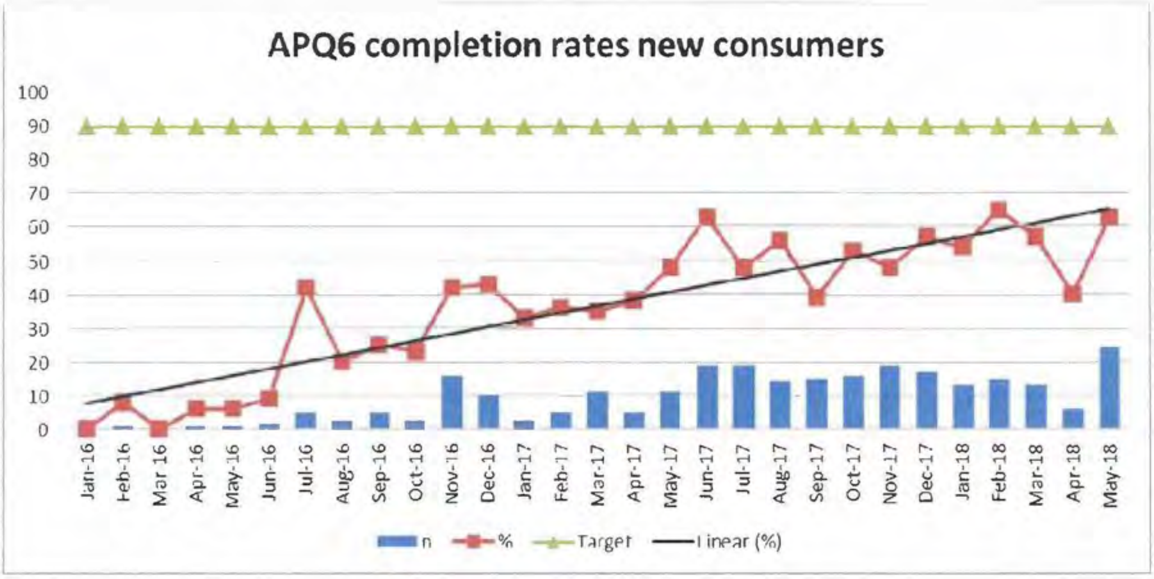
Our strategy	
Learning plan amalgamated in staff members annual discussion	Clinicians expected to identify 1-2 areas of practice interest within their plan, and sign up for relevant learning support 2018 - review of individuals stated area of interest vs actual practice (with team leader and manager)
Reporting re EB practice activity by clinicians	Via research field in contact data Improved ease of data entry for clinicians Via caseload monitoring with team leader re EB activity per consumer

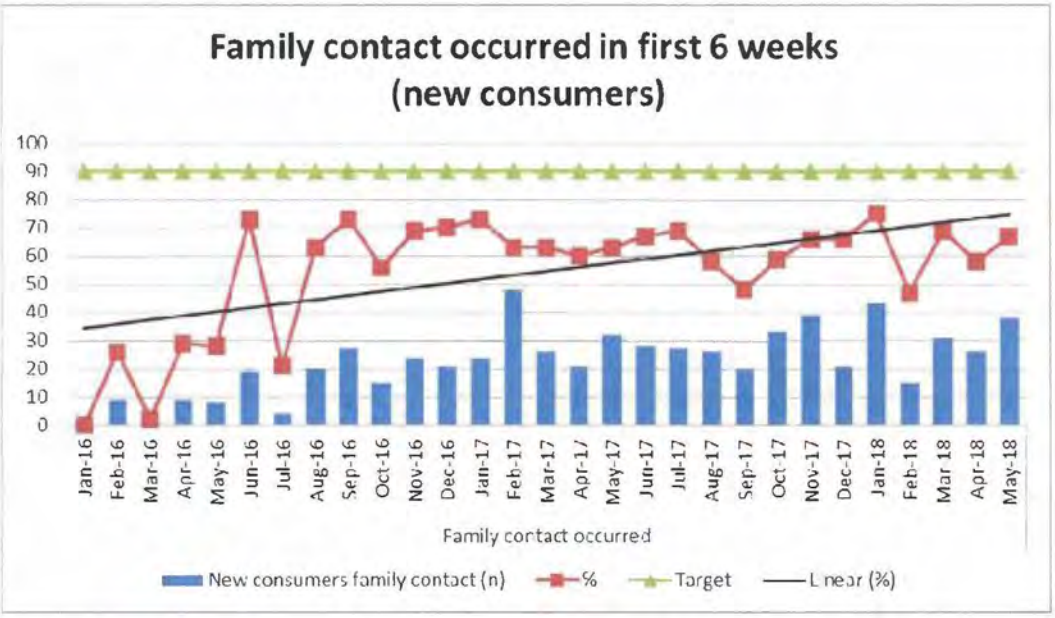
Recovery Plan completion and presentation for those due during the month (trendline added for *n*)

Physical health assessments completed for new consumer presentations



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
n	0	1	0	2	1	2	5	5	7	2	14	11	3	4	14	4	10	17	15	13	17	15	21	20	13	15	11	5	24
%	0	8	0	11	6	9	42	33	35	15	37	48	33	29	45	31	43	57	38	52	45	50	53	67	54	65	48	33	63
Target	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

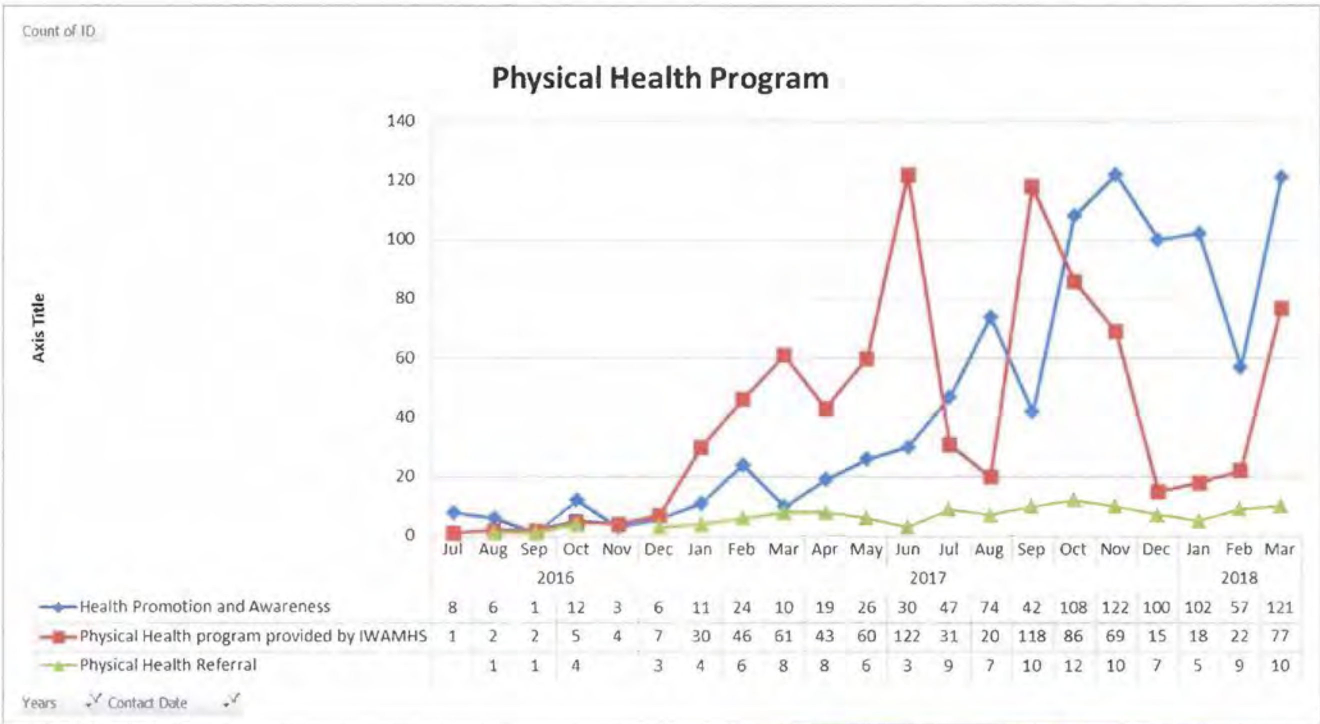

APQ6 completion rates new consumers
100
90
80
70
60
50
40
30
20
10
0
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
n
%
Target
Linear (%)


Family contact occurred in first 6 weeks (new consumers)
100
90
80
70
60
50
40
30
20
10
0
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Family contact occurred
New consumers family contact (n)
%
Target
Linear (%)

CBT fundamentals

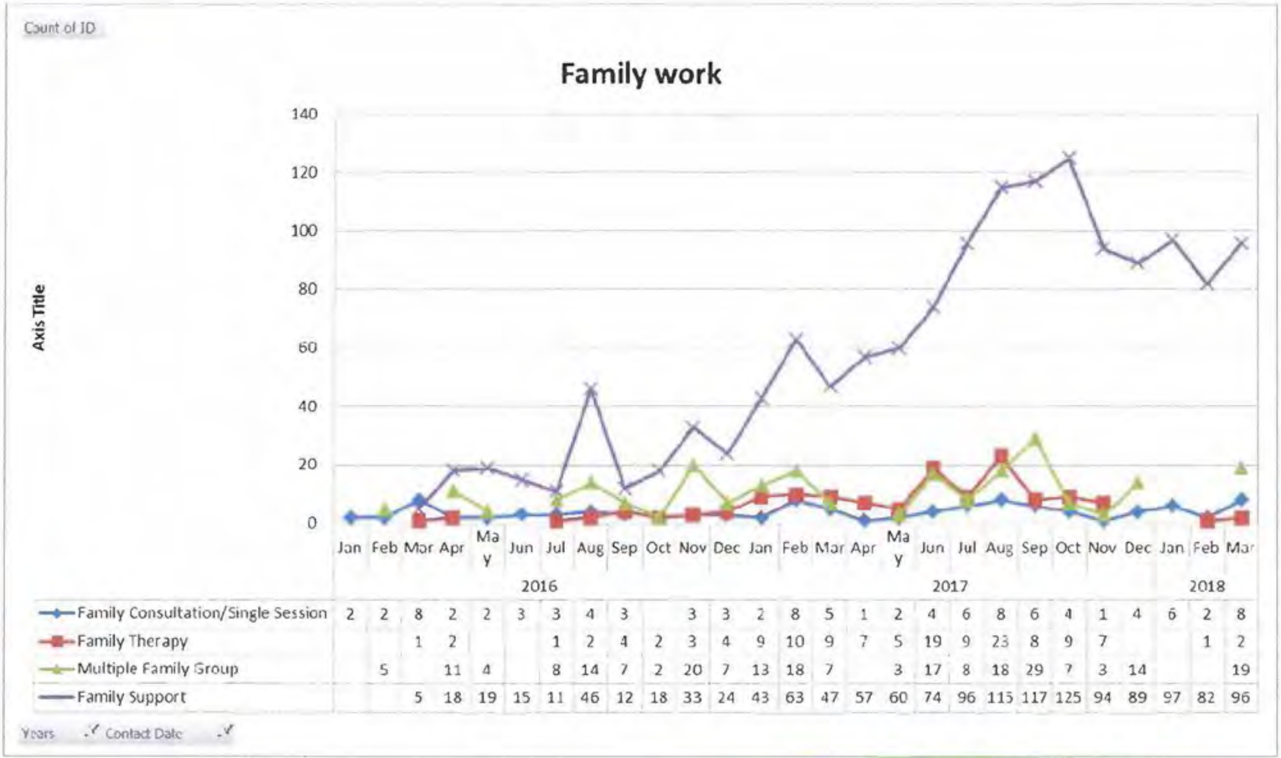
- **Behavioural Activation**
- **Coping Skills Enhancement**
- **Early Warning Signs**
- **Goal Setting**
- **Personalised Psychoeducation**
- **Problem Solving**
- **Relaxation**
- **Self-Monitoring**

CBT fundamentals

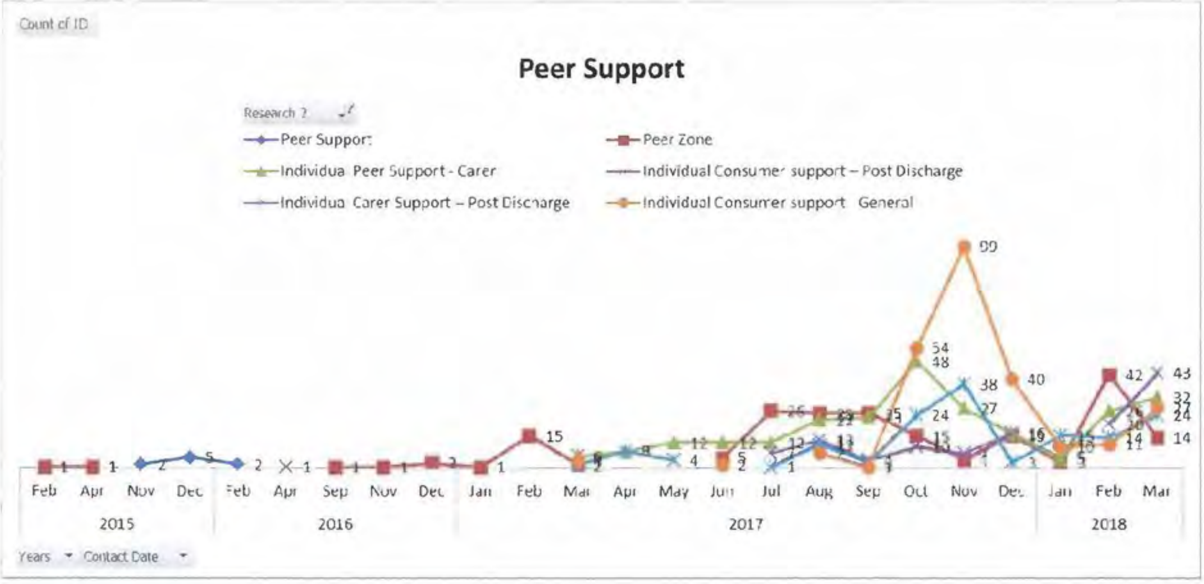


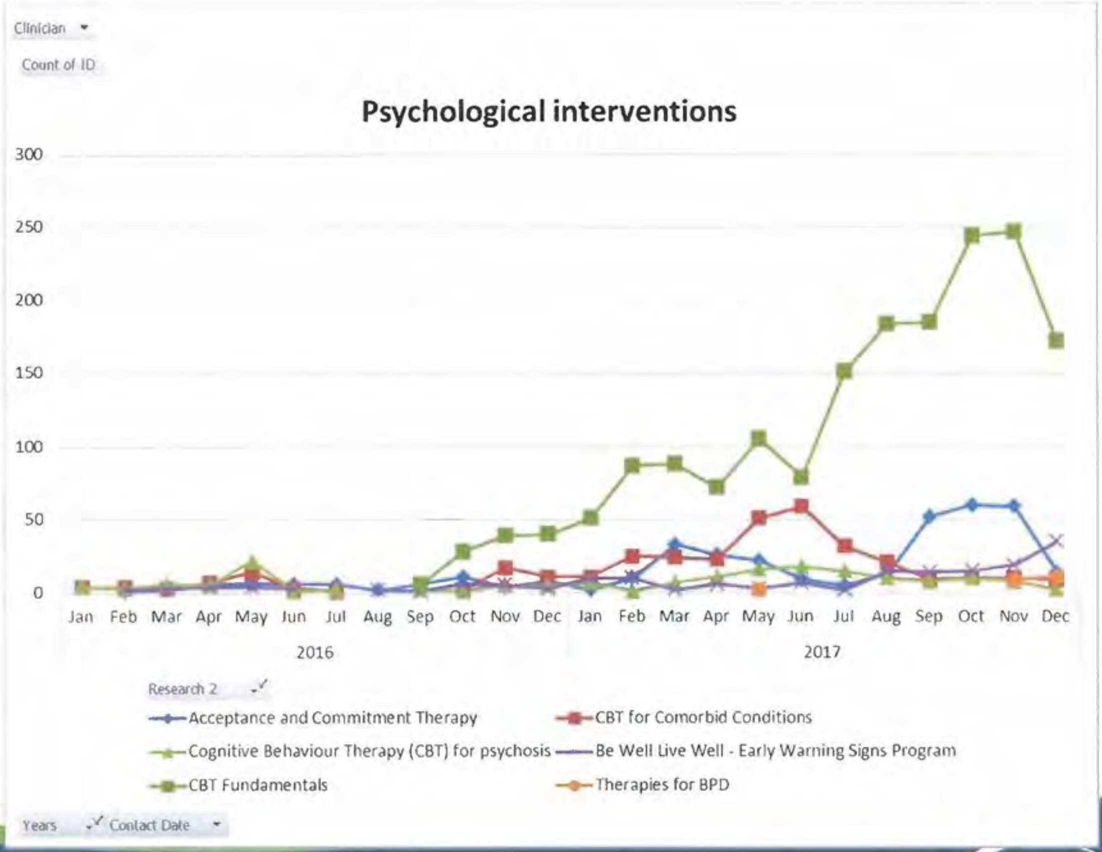
	2016						2017												2018		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Promotion and Awareness	8	6	1	12	3	6	11	24	10	19	26	30	47	74	42	108	122	100	102	57	121
Physical Health program provided by IWAMHS	1	2	2	5	4	7	30	46	61	43	60	122	31	20	118	86	69	15	18	22	77
Physical Health Referral		1	1	4		3	4	6	8	8	6	3	9	7	10	12	10	7	5	9	10

	2016						2017												2018		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Vocational Assessment	2			3			1			1	4		4	7	1	5	2	5	2	3	4
Vocational Intervention		5			1	2		4			1	5	16	12	7	32	8	2	7	3	4
Action over inertia		2	3		8	22	19	28	29	26	41	57	51	46	31	65	26	12	10	5	6



	2016												2017												2018		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Family Consultation/Single Session	2	2	8	2	2	3	3	4	3		3	3	2	8	5	1	2	4	6	8	6	4	1	4	6	2	8
Family Therapy			1	2			1	2	4	2	3	4	9	10	9	7	5	19	9	23	8	9	7			1	2
Multiple Family Group		5		11	4		8	14	7	2	20	7	13	18	7		3	17	8	18	29	7	3	14			19
Family Support			5	18	19	15	11	46	12	18	33	24	43	63	47	57	60	74	96	115	117	125	94	89	97	82	96





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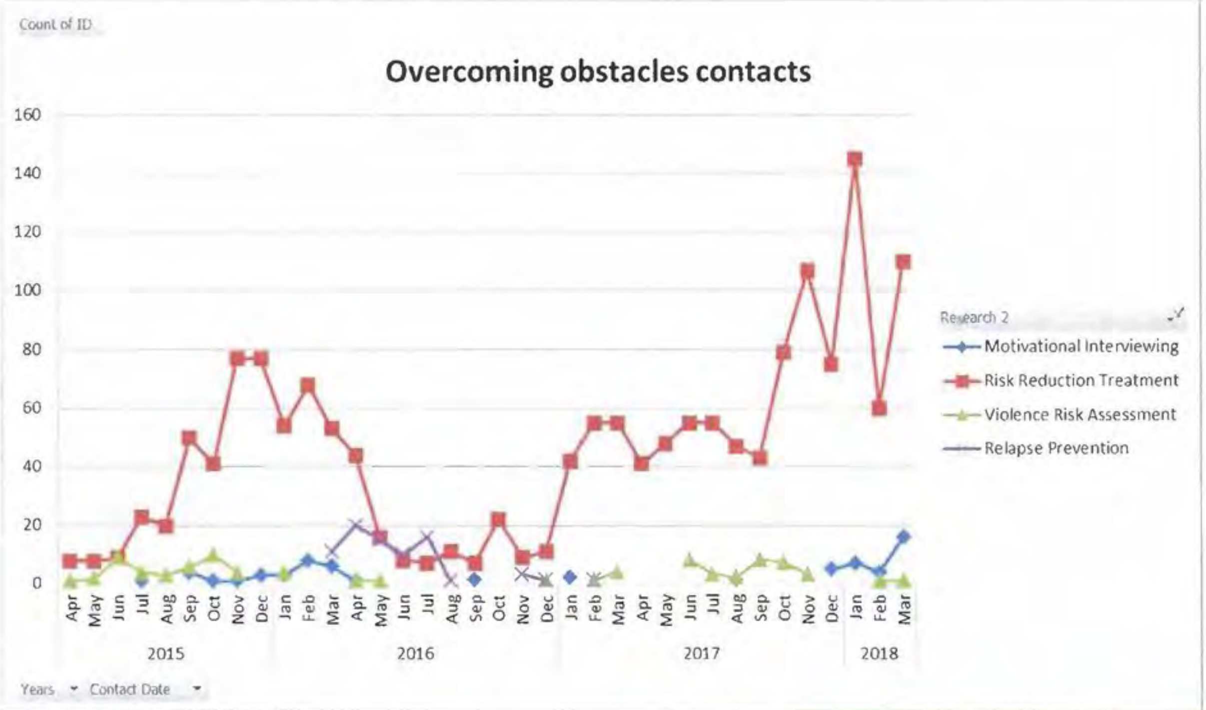

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Conclusions

- Steady improvement in core interventions – more than half of the service consumers experience initial conversations in the practice domains – monitoring platform an important driver
- Attracting good staff, and feedback from senior staff that clinicians now talk much more about psychosocial interventions in clinical review meetings
- Significant program changes related to recruitment of new roles – PeerZone, Physical Health, Employment, and group level interventions
- **BUT**, how do we know that what is actually occurring during clinical contacts is different? Individual level interventions - low and slow rates of change in specific intervention recording via contact data.
- Keep building individual clinician motivation – developing video series – consumer feedback re impact of participation in an evidence-based intervention
- https://www.nwmh.org.au/get-help/what-expect/support-families-carers

Lessons learned

- Engage clinical leaders early
  - Consultant psychiatrist engagement assumed
  - Required specific strategy/expectations from DCS
- Building role functions into positions has been a highly effective strategy – recruit motivated individuals rather than trying to motivate existing workforce, and they then build energy and momentum in the practice domain
- Integration of professional and managerial leadership is essential
- Weathering early low uptake (both professional development and use of interventions)

Next steps

Orientation new staff - New consultants with DCS - New key clinicians in full day training	Commenced 2017
Increased choice for consumers - Promotion of available services for self-referral	Currently developing brochures for consumers and carers
Continued generalisation of practice domains to bed-based services (commenced last year)	Opportunities to bring in more skill mix on inpatient unit to support practice domains.
Contact for further info Gail.Bradley@mh.org.au	

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GB-8

This is the attachment marked 'GB-8' referred to in the witness statement of Gail Bradley dated 26 June 2019.

Specific Evidence Based Interventions

Psychological Interventions	
CBT for Psychosis (CBTp)	Aims to reduce the distress caused by positive symptoms including hallucinations and unusual thoughts, and improve general wellbeing with a range of coping skills.
Acceptance & Commitment Therapy (ACT)	ACT programs are provided for people with distress from psychosis and for people who engage in destructive self-harm to manage emotional distress. It helps people identify values and actions they wish to undertake to make changes in their life, and uses mindfulness, defusion and other techniques to support change.
Therapies for Borderline Personality Disorder	Includes ACT, Dialectical Behaviour Therapy and other approaches to assist people with day to day coping, improve the quality of life and reduce self-harm.
Cognitive –behaviour therapy for co-morbid Anxiety & Depression	People with schizophrenia and other severe enduring conditions may also experience anxiety and depression. CBT helps people change unhelpful habits of thinking, feeling and behaving and promotes well-being.
Be Well Live Well - Early Warning Signs Relapse Prevention Program	A brief individual program (6 sessions) to help consumers self-manage their mental health by identifying the very first warning signs of relapse. A series of exercises are used to explore the person's unique history, triggers, vulnerable times, self-identified strategies and supports. A unique relapse signature and management plan is developed.
Family and Carer Work	
Single Session Family Consultation	A consultative meeting between a practitioner, the consumer and family that aims to clarify their working relationship and help the family identify & address their needs.
Multiple Family Group	Group program delivered to up to 7 families including the consumer on a fortnightly basis over 9 months. Provides psychoeducation, social support and collaborative problem solving. Facilitated by MFG trained staff.
Family Support	Family meetings, info re resources etc with or without consumer present
Family Therapy	Qualified family therapists work with individual families who are experiencing distress.
FaPMI Programs	Programs to support families where the parent has a mental illness. Specific program supports are available for new born, pre-school andprimary school and older children Such as Let's Talk, Champs and Space for Us
Health & Wellbeing	
Assisted Intensive Medication Service (AIMS)	After hours outreach staged support in managing medication using motivational interviewing and CBT strategies.
Medication Alliance	Targeted interventions such as motivational interviewing and CBT based on engagement and assessment in order to support medication adherence.
Health Promotion & Education	Providing information, support and coaching to consumers on various health issues including routine tests, proactive investigations, engagement with a GP.
Wellness Activities - Walking Group - Swim/Gym - AFL Football - Womens Fitness Street Soccer - Breathe Easy (QUIT) - Men's Mondays - Women's Wednesdays	Promoting and supporting activity in order to reduce the effects that may contribute to metabolic syndrome and early intervention that reduces weight gain when starting anti-psychotic medication.
Exercise Physiologist	Individual programs developed by a qualified exercise physiologist for consumers who wish to improve their fitness and general well-being through exercise.
Dietician	Individual nutritional program developed to support weight management.
Vocation, Activity and Participation	
Vocational OT Assessments & Interventions	Individual sessions with consumers to explore career pathways, small business progression, increasing activities, and refine vocational interests.

Action Over Inertia	Delivered individually or in group setting, assists people to get more out of their day by exploring time use, activities of interest, developing routines and supporting uptake of activities.
Pathways to Participation	P2P is a 10 week group program, which is run by a peer support worker (someone with lived experience of mental illness) and occupational therapists to help people get back into the activities they love.
The Works	Starting out with The Works assists consumers to rebuild career aspirations by supporting the consumers vocational recovery. - 6 week program/2 hours per week - Facilitated by both OTs and a peer facilitator
Vocational consultant	Individual sessions with consumers to develop career goals, assist with job seeking and provide support during initial work placement.
Lived Experience	
Peer Zone	Peer-support and recovery education initiative provides a series of up to 20 three hour peer-led workshops. The workshops provide a fun, interactive and safe structure for participants to share their experience, learn self-management and expand their horizons.
Kick Butt	Peer-led support program for people wishing to stop smoking.
Peer-led and co-facilitated recovery Groups	Includes group programs on the adult acute inpatient unit including "Know your rights" and "How do I stay out of here"
Peer Support	Using the Intentional Peer Support model, trained consumer peer workers and consumers use the relationship to look at things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as new things are tried.
Family/Carer Peer Support	Carer peer support workers connect with and listen to family/carers and significant others and alleviate stress by the provision of information in order to navigate the Mental Health Service, as well as facilitate linkages to both internal and external carer/family supports .
Initial Conversations	A consumer led core intervention for all new consumers to the service that looks at providing them with a peer worker for a face to face meet and greet, orientation to the service and discussion about other peer supports on offer
Overcoming Hurdles	
Forensic Risk Management Planning	Uses specialised assessments to identify a person's risk of future criminal offending, and develop an individualised plan to support the consumer.
Forensic Risk Reduction Treatment	Specific treatment to reduce the risk of offending e.g. anger management program "Impulse Tamers".
D2 Motivational interviewing	Uses a specific approach to enhance consumer's motivation to reduce or stop substance use. MI is used to purposefully create a conversation around change, without attempting to convince the person of the need to change, but enabling the consumer to build their own commitment.
Dual Diagnosis Assessment	
QUIT Program	Consumers who wish to stop smoking are supported with regular sessions with a doctor and therapist to monitor their health, provide appropriate nicotine replacement, and provide support and strategies to assist them to quit.
Harm minimisation	Supports consumers to reduce the harm associated with use of alcohol and other drugs including injury, accidental overdose and social impacts through education, needle and syringe programs, and substitution programs.
Relapse prevention	Helps consumers manage relapse as part of the long term strategy of cessation of substance use through prevention. Includes early warning signs for relapse, managing cravings and triggers, managing difficult emotions and responding to a lapse.
Eating Disorder SSCM and CBTe	Approaches to help people self-manage an eating disorder, maintain a healthy weight and improve the quality of life.

Royal Commission into
Victoria's Mental Health System

ATTACHMENT GB-10

This is the attachment marked 'GB-10' referred to in the witness statement of Gail Bradley dated 26 June 2019.

Multiple-Family Group Treatment for English- and Vietnamese-Speaking Families Living With Schizophrenia

Gail M. Bradley, M.Psych.
Grace M. Couchman, D.Psych.
Amaryll Perlesz, Ph.D.
Anh Thu Nguyen, B.O.T.
Bruce Singh, Ph.D.
Colin Riess, B.Med.Sc.

Objective: **This study, which was the first evaluation in Australia of multiple-family group treatment, explored the effectiveness of this approach for a newly arrived non–English speaking migrant group, first-generation Vietnamese families, and for English-speaking families.** ***Methods:*** **Thirty-four pairs of English-speaking consumers and family members and 25 Vietnamese-speaking pairs were randomly assigned to a multiple-family group or a control group. All consumers had a diagnosis of schizophrenia. The multiple-family group intervention (26 sessions over 12 months) was delivered as an adjunct to case management services, which all consumers received. Outcomes, which were measured immediately after treatment and 18 months later, included the number of relapse episodes; the presence and severity of symptoms, as measured by the Brief Psychiatric Rating Scale (BPRS) and the Scale for the Assessment of Negative Symptoms; and social functioning, as measured by the Family Burden Scale, the Health of the Nation Outcome Scale, and the Quality of Life Scale.** ***Results:*** **Relapse rates immediately after treatment were significantly lower for the multiple-family group than for the control group (12 and 36 percent), and relapse rates were also lower during the follow-up period (25 and 63 percent). BPRS ratings were significantly lower for participants in the multiple-family group, and vocational outcomes also improved. The reductions in relapse and symptoms were similar for the English-speaking and the Vietnamese-speaking family groups; sample size precluded statistical analysis of differences.** ***Conclusions:*** **Multiple-family group treatment is an effective cognitive-behavioral intervention in the treatment of schizophrenia. The findings suggest continued application of and research on family interventions for non–English speaking migrant populations. (*Psychiatric Services* 57:521–530, 2006)**

Comprehensive evidence has established family intervention as a powerful tool in the treatment of schizophrenia. After a correlation was found between family tension and relapse (1), a range of interventions has been developed to improve family atmosphere and reduce relapse.

Applying stringent methodological criteria, the Cochrane review of family interventions concluded that interventions incorporating an educational component to improve caregivers' understanding of mental illness, along with additional cognitive-behavioral interventions, are effective in reducing relapse at 12 and 24 months posttreatment (2). Family intervention studies have demonstrated reductions in relapse rates well below the expected two-year cumulative relapse rates of 64 percent obtained for standard care (case management and medication) (3). For instance, Leff and colleagues (4) in a small-scale study with 23 participants reported relapse rates of 36 percent for multiple- and single-family psychoeducation and support. In a study sample of 83 families, Tarrier and associates (5) found relapse rates of 33 percent for behavioral family therapy, including stress management and training in goal setting.

Although the primary focus of outcome studies has been relapse, there is also evidence that family interventions have a positive impact on other

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Ms. Bradley, Dr. Couchman, and Mr. Nguyen are affiliated with the Inner West Area Mental Health Service–Royal Melbourne Hospital, 641 Mt. Alexander Road, Level 2, Moonee Ponds, Melbourne, Victoria 3039 (e-mail, gail.bradley@mh.org.au). Dr. Perlesz and Mr. Riess are with the Bouverie Centre at LaTrobe University in Melbourne, with which Dr. Couchman is also affiliated. Dr. Singh is with the department of psychiatry at the University of Melbourne.

measures of client and family functioning, including negative symptoms (6), family burden (7), vocational outcomes (8), knowledge about schizophrenia (9), quality of life (10), and social adjustment (11).

The relative effectiveness of different types of treatment within family interventions has received little attention. Although all family interventions incorporate psychoeducation, standardized intervention models have focused on a variety of treatments, including behavioral family therapy, incorporating communication training to reduce family conflict and improve problem solving (12); social skills, problem solving, and the development of family support networks (13); and general supportive family therapy (14). Although these models have not been compared, replication studies and studies comparing these treatments with general family support provide some evidence about the consistency of treatment effects.

Studies of behavioral communication training have yielded mixed results. Earlier studies (5) indicated greater efficacy than a more recent trial, which did not show any benefit of intensive behavioral intervention over general family support on relapse or rehospitalization measures (15). Similarly, mixed results have been reported for supportive family therapy. One study reported no difference in outcomes between family therapy and caregiver support groups (14).

Consistent positive treatment effects have been associated with McFarlane's (16) multiple-family group intervention, an adaptation of Hogarty's (11) approach. Both are based on psychoeducation, problem solving, and development of social support networks. In a large-scale multisite study of 172 families that compared single- and multiple-family treatment, cumulative two-year relapse rates of 16 percent were reported for the multiple-family groups, compared with 27 percent for single-family therapy (17). Multiple-family treatment also showed superior outcomes in other measures of functioning, such as employment and perceived family burden. The positive effects of multiple-family group interventions that were seen in multisite trials have also been found in natural clinical settings (6,17). In these settings multiple-family groups were shown to be more cost-effective than standard care; savings from reductions in inpatient hospital admissions and from use of the group treatment format were estimated to yield a cost-benefit ratio of 1:17 for multiple-family group treatment compared with standard care (16).

Some variation is evident in the impact of the multiple-family group intervention on specific symptom profiles, which may be related to the types of patient groups in different studies. For instance, McFarlane and colleagues (16) used the multiple-family group intervention with people in an acute phase of illness and reported significant changes in acute symptoms. In contrast, a study by Dyck and associates (6), which involved 63 people with chronic schizophrenia in an outpatient setting, found that acute symptoms of consumers who received multiple-family group treatment were not affected but that their negative symptoms improved.

Very little research has explored the impact of family intervention in migrant groups, even though it could be argued that these groups have the greatest need for family support.

Several cross-cultural applications have identified family interventions as an efficacious treatment in international settings in which the cultural identification of the treatment group is consistent with the dominant culture (18,19). However, very little research has explored the impact of family intervention in migrant groups, even though it could be argued that these groups have the greatest need for family support. Common experiences of stress, isolation, and burden experienced by families dealing with mental illness are likely to be further intensified for newly settled migrant families because of language and communication difficulties, reduced access to extended family supports, and lack of knowledge of mental health services.

For example, Klimidis and associates (20) found lower rates of use of adult community mental health services among people of non–English-speaking backgrounds in Victoria, Australia, particularly among Asian and South East Asian communities. However, the only study that investigated the effectiveness of family interventions with a migrant population showed an adverse outcome. Telles and colleagues (21) assigned 40 Hispanic-American families of non–English-speaking backgrounds to behavioral family management or a case management control group. Behavioral family management made no significant clinical contribution beyond case management and medication, and compared with individual treatment, behavioral family management actually exacerbated symptoms of individuals who were defined as "less acculturated." The authors suggested that the psychoeducation and support packages developed for English-speaking cultures may contain directives that are culturally dystonic, such as expressing negative emotions in the presence of an authority figure within the family. Such findings have prompted some researchers to recommend caution in using family interventions for individuals from non-English-speaking backgrounds (22). However, very little attention has been directed to modifying family interventions to incorporate culturally sensitive practice, despite suggestions that cultural factors may have a profound influence on the way services are received and their effectiveness (23).

Our study compared outcomes for participants in a multiple-family group intervention for people with schizophrenia and their caregivers and a case management control group. The study sought to extend the multiple-family-group approach with appropriate cultural modifications to a newly arrived migrant group with a non–English-speaking background—first-generation Vietnamese families.

Methods

The study was conducted between September 1997 and July 2004 in the community mental health program of the Inner West Area Mental Health Service–Royal Melbourne Hospital in Melbourne, Australia. The service is one of 21 area mental health services funded by the state government and covers a geographical area that includes the central business district of Melbourne and a corridor of suburbs through the inner west area, with a population of 160,000 people.

The sample consisted of 59 consumers and their caregivers, of whom 34 pairs were English speaking and 25 were Vietnamese speaking. All consumers were recruited from outpatient continuing care settings. English-speaking consumers were recruited from the Inner West Area Mental Health Service. Although all the English-speaking consumers were born in Australia, two of the caregivers were born overseas. These two individuals had lived in Australia for more than 25 years and were proficient in English. Vietnamese-speaking consumers were recruited from the Inner West, Mid West, and South West Area Mental Health Services. All Vietnamese-speaking consumers and caregivers were born in Vietnam and had arrived in Australia as migrants or refugees between 1978 and 1985. A formal measure of acculturation was not used. However, acculturation and social adjustment has been shown to be strongly related to English fluency (24). Because 20 of the Vietnamese consumer-caregiver participants (80 percent) were not fluent in English and an interpreter was required for basic communication, the sample was considered to have a low level of acculturation.

Individuals eligible for inclusion in the study were those who had a diagnosis of schizophrenia, schizoaffective disorder, or schizophreniform disorder; who were aged between 18 and 55 years; and who had a minimum of ten hours of contact with family members each week. Consultant psychiatrists who had a minimum of 15 years of experience in public mental health settings used *DSM-IV* criteria to make clinical diagnoses. The presence of a comorbid diagnosis of substance use disorder was also determined. Institutional approval for the study was obtained from the Royal Melbourne Hospital research and ethics committee, and informed consent was obtained from all project participants.

The study followed standardized informed consent protocols to inform both consumer and family members about the purpose of the research, the practical requirements of the study, voluntary participation, and their rights in terms of confidentiality. Clients and caregivers were informed that because the research aimed to explore the effectiveness of standard case management compared with standard case management plus family treatment, some families would be offered family programs at random, and that consumer and family changes would be evaluated over 12 months of participation in both individual and family service programs. The plain-language statement and consent form was translated for Vietnamese-speaking consumers and caregivers. Consumers were initially invited by their case manager to take part in the service evaluation study, which consisted of two interviews over 14 months. They were asked to invite a caregiver to participate in the assessments. This procedure yielded a pool of participants from which the randomization process could occur.

After collection of pretreatment data, consumers and their caregivers within each cultural group were allocated randomly to a treatment or control condition by a staff member who drew names from a canister and, without looking at the names, assigned them to experimental and control groups. Treatment condition participants were then invited to take part in the multiple-family group intervention for 12 months.

Of the 73 consumers who met inclusion criteria and who were invited by their case managers, 59 consumers-caregiver pairs agreed to participate in the evaluation study. Caregivers included parents, siblings, and spouses. Of the 59 pairs, nine did not complete the data collection procedure after treatment or at 18 months (four in the control group and five in the treatment group). Four pairs assigned to the treatment condition declined to join the family group (three English speaking and one Vietnamese speaking). One participant in the multiple-family group died from a heroin overdose. A participant in the control group was lost through relocation, and two participants in the control group refused to complete the follow-up assessments. Follow-up data on relapse were not available for one participant in the control group who died from an overdose. Caregiver data were missing for two participants in the control group; one caregiver became ill, and a caregiver of a consumer who died declined to participate.

Clinical and social functioning assessments

Assessments were conducted using standardized measures with validated psychometric properties. They included the expanded Brief Psychiatric Rating Scale (BPRS) (25), the Scale for the Assessment of Negative Symptoms (SANS) (26), the Health of the Nation Outcome Scale (HoNOS) (27), and the Quality of Life Scale (QOL) (28). Caregiver burden was measured with the Family Burden Scale (29). Independent researchers, who were blind to study condition, conducted the assessments. They were a clinical psychologist with experience in mental health and an experienced Vietnamese psychiatric-disability support worker who is also a qualified interpreter and translator. Both researchers underwent brief specific training in the use of the study measures at the Early Psychosis Prevention and Intervention Centre. The BPRS standardized interview format was used, with the addition of the guidelines provided by Ventura (30). Video training was used to standardize the researchers' use of the QOL. A valid interrater reliability quotient was not achievable because of the incongruence between same-language and interpreted-language assessment.

Relapse

All participants were monitored over the course of the study for medication compliance and mental state. Case managers were asked to identify changes in symptoms using a monthly checklist that required them to rate on a 4-point scale any changes in frequency of contact, required social support, level of monitoring or interventions required, medication compliance, and changes in medications. The checklist also required case managers to indicate if they considered the consumer to be at risk of relapse or undergoing relapse. Examinations of patients' files were conducted after the study by researchers who were blind to the treatment condition to determine whether clinician-identified changes in symptoms constituted early-warning signs of relapse or full relapse. Early warning signs were defined as mood changes, a significant increase in persistent symptoms, increased contact with services, and use of rescue medication. Relapse was defined as the reemergence of frank psychotic symptoms after a period of remission of such symptoms, persisting continuously for a minimum of seven days and requiring intensive community treatment or hospital admission.

Time to relapse, time to hospitalization, number of episodes of relapse, and relapse duration were recorded. Data on early warning signs and relapse were collected at an 18-month follow-up by reviewing files and examining hospital admission data and by mailing questionnaires to current treatment providers for consumers who had been discharged from the service.

Control and treatment conditions

The case management intervention that was provided to all participants and that constituted the control condition consisted of regular appointments with a case manager and doctor to assess mental health and to provide medication and individual psychosocial rehabilitation on the basis of consumers' needs. Appointment frequency was every two to three weeks on average, and the sessions lasted from 30 minutes to one hour. Family contact was provided on an individual basis as required for all participants in the control and treatment groups. Family contact consisted of phone or direct contact and focused on providing psychoeducation, monitoring the consumer's mental state, and giving general support. Case management for Vietnamese participants in the control group was provided by a Vietnamese bilingual case manager when possible or with the use of Vietnamese interpreters.

Consumers assigned to multiple-family group treatment received the intervention as an adjunct to the standard case management intervention described above. Consumers' psychiatric registrars or psychiatrists did not participate in the group. On the basis of recommendations from meta-analyses of controlled outcome studies indicating that family treatment is effective when provided for a minimum of six months (31), families were regarded as having received the intervention if they attended 50 percent of the 26 sessions over the 12-month treatment period.

The multiple-family-group procedure was followed with minimal variation (32). Consumers and caregivers were provided up to three single-family joining sessions (described below) and then invited to attend two half-day multiple-family psychoeducation sessions. The family psychoeducation sessions provided information about schizophrenia using the approach described by Anderson and colleagues (33). The sessions gave family members the opportunity for informal social networking. Topics included the nature of the illness, treatment approaches (medication and psychosocial), consumer and family needs, common family reactions to illness, common problems that consumers and families face, and guidelines about what the family can do to help. The education was provided to the families by psychiatrists, psychologists, social workers, and occupational therapists. Each group of six or seven consumer-caregiver pairs was then invited to participate in a multiple-family group with two trained group leaders; groups met every other week for 12 months.

Although the multiple-family group intervention is generally used for two years, funding constraints necessitated a briefer intervention. Two Vietnamese-speaking and two English-speaking groups were conducted during the course of the study. Key components of each of the multiple-family group meetings were initial socializing, a "go-round" of current concerns for each family, a review of problems discussed in the previous meeting, and a combination of a discussion about a general topic and problem solving with a single family about a particular issue.

Staff training was initially provided by a three-day national workshop conducted by William McFarlane that outlined the multiple-family group method. The original multiple-family group format was varied only with respect to the inclusion of consumers in the family education sessions. Each of the English-speaking and Vietnamese-speaking groups had two therapists—a primary therapist and a support cofacilitator. The English-speaking and Vietnamese primary therapists were consistent for two intakes of the two cultural groups during the study to minimize variations in the application of the intervention. A cofacilitator was assigned to each of the four groups from a pool of two English-speaking and two Vietnamese-speaking therapists (a total of six therapists). Although treatment fidelity was not formally evaluated, the standardized treatment manual was used by group leaders. The manual was a critical tool in directing the structure and content of the sessions to maintain consistency of the therapeutic approach.

Regular supervision was provided to all group therapists by the lead primary therapist to the other five therapists. She was a senior psychologist and family therapist who was highly familiar with the McFarlane model. Additional external consultation was provided by a therapist at a specialist family therapy service, the Bouverie Centre. The theoretical orientation of the supervising therapists could be broadly described as systemic and congruent with McFarlane's approach.

Advice about cultural modifications to the multiple-family group intervention was provided by a Vietnamese therapist, who is part of a network of transcultural mental health specialists supported by the Victorian Transcultural Psychiatry Unit, a specialist teaching and research center. Cultural adaptations of the program included the use of Vietnamese-speaking staff for all aspects of service provision within the program. Family joining sessions were conducted informally on an outreach basis in the homes of the Vietnamese families to maximize the likelihood that families would engage with the service and to provide an opportunity to include as many family members as possible. Psychoeducation sessions acknowledged common ethnospecific explanatory models of illness before the biopsychosocial model of illness was outlined. Traditional alternative healing practices, such as herbal treatments and use of religious leaders, were acknowledged alongside Western approaches.

Statistical analyses

Because our objective was to determine whether the multiple-family group intervention would improve outcomes beyond those of case management alone for both Vietnamese-speaking and English-speaking groups, treatment effects were examined for the combined cultural groups. Although determining whether a specific treatment would be more effective for a particular cultural group was the secondary focus, such an analysis was beyond the scope of the study reported here because small samples provided insufficient statistical power. However, because the potential for negative outcomes of family treatment for migrant populations is of clinical and research importance, we examined and report trends in the data related to this issue.

Differences between the groups on the relapse measures were explored by using chi square analyses and survival analysis methods. To determine whether multiple-family group treatment improved functioning in other domains, dependent variables for which pre- and posttreatment scores were available were submitted to a series of analyses of variance—treatment (multiple-family group or case management) by time (pretreatment or posttreatment). The main hypotheses were tested by the presence of a group-by-treatment interaction on each measure using the Statistical Package for the Social Sciences (version 9.0).

Table 1

Demographic and clinical characteristics at study entry among persons with mental illness who participated in a multiple-family group intervention or in a control group

	Multiple-family group (N=25)		Control group (N=25)	
Characteristic	N	%	N	%
Age (mean±SD years)	33.6± 6.68		34± 9.60	
Sex				
Female	18	72	17	68
Male	7	28	8	32
Cultural background				
English speaking	13	52	17	68
Vietnamese speaking	12	48	8	32
Caregiver relationship				
Parent	19	76	18	49
Spouse	6	24	2	8
Sibling	0	—	5	25
Psychiatric hospitalizations in the 12 months before treatment (mean±SD)	.60±1.5		.29±.86	
Antipsychotic medication				
Second generation	17	68	22	88
First generation only	5	20	4	16

Results

Sample characteristics and attendance

Demographic characteristics of the sample are presented in Table 1. The mean age of participants in the control and treatment groups was about 34 years, and a majority of participants in the overall sample were female (70 percent) in each condition. The most common type of caregiver-consumer relationship was parent–adult offspring in both the multiple-family intervention (76 percent) and the control group (49 percent), although six caregivers in the Vietnamese multiple-family group were spouses (24 percent). Loss to follow-up was disproportionately higher among Vietnamese participants in the control group than among Vietnamese participants in the treatment group, either through relocation or refusal to participate in follow-up assessments.

The groups were compared for baseline differences by using chi square analyses and t tests for independent samples. Hospitalization history for the 24 months before study entry was examined to compare illness severity of the treatment and control groups. No significant differences between the groups were found. Of the total sample, 21 participants (42 percent) had received hospital treatment in the 24 months before baseline. Of the total sample, ten (20 percent) had an additional diagnosis of a substance use disorder. No difference was found between the groups on this variable. No differences were found between the treatment and control groups in medication compliance, and the mean self-reported monthly compliance rate was high (91 percent for the total sample).

Table 2

Measures of relapse among participants in a multiple-family group intervention or a control group

Measure (sample size)	Multiple-family group		Control group				
	N	%	N	%	χ^2	df	p
Persons relapsing							
End of treatment (N=25)	3	12	9	36	3.95	1	.048
18-month follow-up (N=24)[a]	6	25	15	63	6.86	1	.009
Episodes of relapse over the study period (N=25)	10		22		4.61	48	.032
Persons with multiple relapse episodes (N=25)	1	4	4	16	5.27	4	ns
Two	0	—	3	12			
Three	0	—	1	4			
Four	1	4	0	—			
Persons with any episode or early-warning signs							
End of treatment (N=25)	12	48	12	48	.20	1	ns
18-month follow-up (N=24)[a]	16	70	14	56	.94	1	ns

[a] Between the start of the intervention and the 18-month follow-up

Medication prescribing patterns were examined to determine whether there was any variation between groups in the use of first- and second-generation antipsychotics. No differences were evident in prescribing patterns between the groups. A significant pretreatment difference in participation in employment was found (N=50, χ^2= 8.0, df=47, p<.01); nine participants in the control group engaged in vocational training or part- or full-time employment, compared with one participant in the multiple-family group. No differences in English fluency were found between the Vietnamese-speaking treatment and control groups, suggesting a low level of acculturation for all Vietnamese participants.

Further tests on the dependent measures found no significant pretreatment differences between the treatment and control groups in scores on the BPRS, SANS, QOL, HoNOS, or Family Burden Scale. Pretreatment differences in the dependent measures between the two cultural groups were also examined. Scores were comparable for all of the variables with the exception of family burden. Family burden was rated as significantly higher among Vietnamese participants than among English-speaking participants (t= –8.2, df=47, p<.001).

All families participating in multiple-family group treatment attended the initial family psychoeducation day. As noted above, research indicates that family treatment is effective when provided for a minimum of six months. Attendance levels at the family group sessions (held every two weeks) were high; only two families in the treatment groups attended for less than six months. For the English-speaking groups, all but two families attended consistently for the 12 months of treatment. Two families attended inconsistently but continuously throughout the 12 months, attending approximately half the scheduled sessions (equivalent to six months of participation). In the Vietnamese-speaking multiple-family groups, all but two families attended for more than a total of six months. Seven families attended consistently for 12 months, one family for nine months, one family for six months, and two for less than six months (three and two months).

Relapse

At the end of the 12-month intervention, relapse data were available for the whole sample. Data were incomplete at 18 months because of the death from a heroin overdose of one participant in the Vietnamese control group, the inability to locate another Vietnamese participant, and the death of a participant in the English-speaking treatment group. During the 30-month course of the study, 21 of the remaining 48 consumers (44 percent of the total sample) experienced a relapse. As shown in Table 2, a significantly lower incidence of relapse was observed for participants who received the multiple-family group treatment; three participants (12 percent) experienced a relapse during the 12-month intervention period, compared with nine (36 percent) in the case management control group. At 18 months after the intervention, the difference in relapse rates was wider; six participants (25 percent) in the multiple-family group relapsed since the start of treatment, compared with 15 participants (63 percent) in the control group.

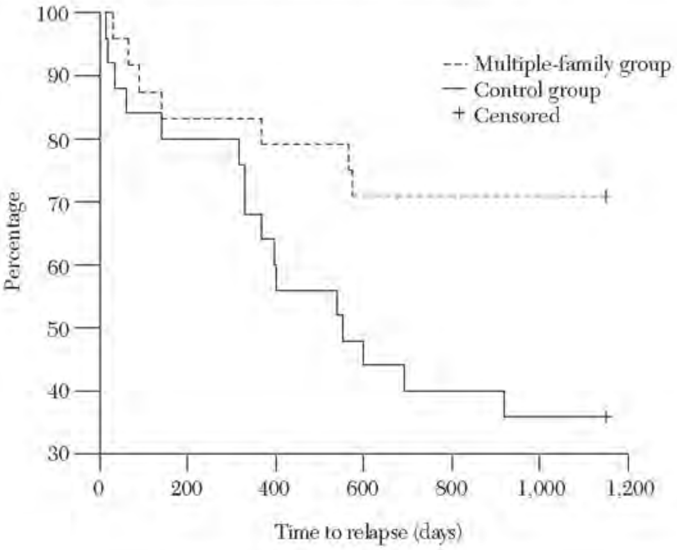
The duration of relapse was equivalent between the treatment and control groups. Multiple episodes of relapse were relatively infrequent, and no differences between the groups were evident.

Although the subsamples are too small for statistical analysis, it is interesting to examine relapse rates as a function of ethnicity as well as treatment condition. The overall trend identified for the combined cultural groups was consistent for Vietnamese participants. Vietnamese participants in the multiple-family intervention demonstrated low relapse rates immediately after treatment—8 percent (one participant), compared with relapse rates of 25 percent (two participants) for Vietnamese participants in the control group. At 18 months the relapse rate for Vietnamese participants in the multiple-family intervention was 27 percent (three of 11 participants), compared with 43 percent (three of seven participants) for the Vietnamese control group.

Figure 1 shows the Kaplan-Meier survival curves for time to relapse for the treatment and control groups. A single covariate (treatment condition) estimates the effect. Mean time to relapse for participants in the treatment condition was 890 days, compared with 642 days for the control group. A significant difference between the curves was found for the two groups (log rank=5.22, df=1, p=.02). A Cox regression model fitted to the data led to the estimate that time to relapse in the treatment group was .37 times the time to relapse in the control group (χ^2=5.28, df=1, 95 percent confidence interval=.151 to .899, p=.028).

Figure 1

Kaplan-Meier survival curves for time to relapse among participants in a multiple-family group intervention and in a control group



Changes in symptom

We did not find any group differences in early-warning signs of relapse were identified for, as measured by reports of mood changes, a significant increase in persistent symptoms, contact with emergency services, or use of rescue medication

Table 3 presents mean scores for the groups on each measure. A significant interaction between treatment condition and time was found for BPRS scores. Post hoc pairwise comparisons (matched-pairs t tests) indicated a significant reduction between pre- and posttreatment BPRS scores for the multiple-family group (t=3.4, df=24, p<.01) but no difference for the control group. Further analysis of the four standard subscales of the BPRS (34) was conducted to explore the changes in greater detail. The analysis showed a significant interaction between treatment condition and time for the disorganization subscale (F=4.42, df=1, 46, p=.05) (conceptual disorganization, tension, and mannerisms); group differences showed a trend toward significance for thought disturbance (F=4.35, df=1, p=.05) (suspiciousness, hallucinatory behavior, grandiosity, and unusual thought content). Post hoc comparisons indicated that scores were significantly lower for participants in the multiple-family group on the thought disturbance subscale (t=2.4, df=24, p<.05) and showed a

Table 3

Pre- and posttreatment scores on outcome measures for participants in a multiple-family group and a control group[a]

		Pretreatment		Postreatment				
Measure and group	N	Mean	SD	Mean	SD	F[b]	df	p
BPRS total score[c]						5.87	1	.019
Multiple-family group	25	50.84	11.89	44.12	8.82			
Control group	25	46.00	9.44	46	10.44			
SANS[d]						.43	1	ns
Multiple-family group	25	33.73	16.89	32.78	15.31			
Control group	23	30.66	13.54	26.94	15.59			
QOL[e]						.68	1	ns
Multiple-family group	25	54.82	13.67	58.17	14.25			
Control group	21	54.39	14.56	63.22	22.34			
HoNOS[f]						1.92	1	ns
Multiple-family group	25	11.00	5.82	9.26	4.63			
Control group	24	8.61	4.81	7.66	4.85			
Family Burden Scale[g]						.26	1	ns
Multiple-family group	24	27.78	19.38	18.95	15.39			
Control group	22	21.22	17.65	9.38	8.10			

[a] Scores at the start of the 12-month intervention and immediately following it

[b] For treatment-by-time interaction

[c] Brief Psychiatric Rating Scale. Possible scores range from 0 to 168, with higher scores indicating greater severity of symptoms.

[d] Schedule for the Assessment of Negative Symptoms. Possible scores range from 0 to 125, with higher scores indicating greater severity of negative symptoms.

[e] Quality of Life Scale. Possible scores range from 0 to 126, with higher scores indicating greater quality of life.

[f] Health of the Nation Outcome Scale. Possible scores range from 0 to 48, with higher scores indicating more problems with health and social functioning.

[g] Possible scores range from 0 to 62, with higher scores indicating greater caregiver burden.

trend toward significance (p<.07) on the disorganization subscale, although no significant change was noted for the control group.

No significant effects for SANS scores were found for the multiple-family group or the control group. Because of the small sample, data for the Vietnamese participants were not subjected to significance tests; however, trends for the Vietnamese sample were consistent with the findings for the combined groups. A mean± SD reduction in BPRS scores of 8.5± 11.15 points was found for the Vietnamese-speaking multiple-family group, compared with a reduction of 1.8±10.37 points for the Vietnamese-speaking control group. This finding suggests that the culturally adapted multiple-family group was effective for Vietnamese participants in reducing psychiatric symptoms, whereas previous reports have found exacerbation of symptoms after family interventions.

Adjustment and role performance

The effect of the multiple-family group intervention on employment is difficult to determine because of significant pretreatment differences favoring the control group. At treatment entry, nine participants in the control group and one participant in the multiple-family group were engaged in employment-related activity (χ^2=8.0, df =1, p=.005). Immediately after the intervention, differences between the groups were not found; seven participants in the control group and five in the multiple-family group engaged in employment. At 18 months postintervention, data were available for only 40 participants. The data indicated that differences between the groups had further diminished; five participants in each condition engaged in employment-related activity, suggesting that employment outcomes had worsened over time for the control group while they improved for the treatment group.

Outcomes for other measures of adjustment and functioning are presented in Table 3. No group differences were found in scores on the HoNOS, Family Burden Scale, or QOL. A main effect of time on family burden was identified (F=28.61, df=1, 48, p<.001), indicating that both the multiple-family group and case management control were highly effective in reducing both objective and subjective measures of burden.

Discussion

The results of this study add to the growing evidence base for the effectiveness of cognitive-behavioral family interventions in the treatment of schizophrenia. Numerous researchers have noted that the benefits shown during the course of family treatment are not only maintained but strengthen over time, leading to extended periods without relapse and consistent relapse reduction rates of 25 percent at two-year follow-up (11,15). Consistent with these studies, our study found that multiple-family group treatment extended time to relapse and that treatment effects increased over time, with a greater contraction of relapse rates for the multiple-family group. Our relapse findings are also consistent with the literature on multiple-family groups; previous findings indicate two-year cumulative relapse rates of 25 percent (16,17). It is interesting that outcomes for relapse were similar in our study, in which only half the standard length of multiple-family group treatment was provided (12 months instead of 24 months).

The Vietnamese families reported extremely high rates of burden compared with the relatively low levels reported by the English-speaking families.

Also in accordance with previous findings (16), BPRS symptom ratings in our study were significantly lower for the multiple-family group than for the control group immediately after the intervention. Subscale changes were significant for thought disorder and approached significance on positive symptoms such as paranoia, hallucinations, and conceptual disorganization. Unlike Dyck and colleagues (6), we did not identify any effect of multiple-family group treatment on negative symptoms, even though our sample was similar. Because the treatment protocol is standardized, it is not clear why different treatment outcomes were obtained for negative symptoms. The focus and content of the multiple-family groups may vary depending on the extent to which different types of symptoms are prioritized by families for discussion, problem solving, and psychoeducational input, which may lead to variations in the impact of treatment on different types of symptoms. It is also possible that the shorter treatment in this study reduced the impact of the intervention on negative symptoms.

The outcomes related to employment also suggest a positive impact of the multiple-family group intervention compared with the control intervention. Although the treatment group had significantly lower levels of employment than the control group at study entry, by the end of the follow-up period differences between the groups had disappeared, with equal numbers of participants engaged in employment-related activity. Despite pretreatment differences, it is clear that over two and a half years, employment outcomes had worsened for the control group and improved for the treatment group. The finding highlights the deleterious impact of relapse on functioning, as evidenced by losses of employment for control group participants, who experienced much higher relapse rates, and employment gains for participants in the multiple-family group, who demonstrated longer periods of remission between episodes. These findings are also consistent with numerous reports of positive employment outcomes associated with multiple-family group treatment (8,17) and support McFarlane and colleagues' (8) proposed interaction between symptom stability and vocational outcomes.

In contrast to other studies demonstrating that multiple-family group treatment is superior to other forms of treatment in reducing family burden (35), our study found that both the multiple-family group treatment and case management control treatment were highly effective in reducing family burden. Although the finding provides evidence for the effectiveness of the family-sensitive case management approach used in the mental health service, it is also possible that culture is a confounding variable. Highly significant pretreatment cultural differences were found, with Vietnamese families reporting extremely high rates of burden compared with the relatively low levels reported by English-speaking families. It is not possible to determine whether this finding was a specific factor related to Vietnamese ethnicity or an outcome of the migration experience. Intuitively it appears likely that relocated families who experience higher levels of vulnerability and isolation and the absence of an extended family to diffuse burden would be more responsive to any effective form of help. It is possible that both case management and the multiple-family group provide highly effective alternative support networks for problem sharing, problem solving, and emotional support and for reducing isolation.

It is also possible that the predominance of caregivers who were spouses among Vietnamese participants may have increased the levels of burden because of the additional impact of dependency factors specific to couples. Our finding of high levels of burden for Vietnamese families is also consistent with the results of other studies that identified high ratings of burden for Asian families in Hong Kong and China (36). Our finding further highlights the importance of providing adequate caregiver support, particularly for people from sociocentric cultures in which families assume a high level of responsibility for members with severe mental illness.

The results of this study provide an important contrast to previous evidence indicating an adverse outcome of family interventions in a migrant population (21). Although it was not possible to test statistically because of the small subsamples, the data trends suggest that the Vietnamese-speaking families and the English-speaking families responded similarly to the multiple-family group intervention in terms of relapse and BPRS symptom ratings. The findings related to symptom ratings are of particular interest. Unlike Telles and colleagues (21), who found that family intervention resulted in an exacerbation of symptoms among poorly acculturated Hispanic-American families, we found a reduction in BPRS ratings for both the Vietnamese- and English-speaking multiple-family group participants.

These findings must be interpreted cautiously because they were not subjected to significance tests and were from small subsamples. It should also be noted that the identified trend is specifically related to a Vietnamese migrant population and cannot be generalized to other migrant groups. There may be subtle interactions between characteristics of specific ethnic or migrant subcultures and treatment modality that have different effects on outcomes. Nevertheless, the trend does provide a basis for further use and evaluation of culturally modified family interventions for newly arrived non–English-speaking families and should provide a counterbalance for researchers and clinicians who may have been deterred from further exploration of the effects of family intervention with migrant populations by previous reports of symptom exacerbation.

Numerous writers have drawn attention to the difficulty of providing family support as a routine part of treatment in mental health services (37). The findings of this study prompt further reflection about the influence of cultural values in shaping service philosophy and configuration. In Asian cultures the family is a crucial social structure (38), and the burden of illness becomes a joint family obligation, with multiple members engaged in treatment. In contrast, Western cultural values emphasize individualism—for example, protection of the rights of the individual to privacy and confidentiality as well as independent living. Special attention to structural changes in the workplace may be necessary to counterbalance individualism in the mental health service culture to ensure the implementation of family-sensitive service systems.

The small sample was the principle limitation of the study, which prohibited more rigorous examination of the interaction of treatment and ethnicity. Although Vietnamese people represent one of the larger non–English-speaking communities in the inner west area of Melbourne, they tend to be represented in small numbers in the mental health service, and recruitment of Vietnamese participants proved problematic. Additionally, a large proportion of Vietnamese participants in the control group were lost to follow-up through relocation or refusal to participate. This outcome is itself of interest and suggests greater engagement of Vietnamese consumers and caregivers with services that are delivered with a focus on family participation. The effect of mixing spousal and parental caregivers within the Vietnamese multiple-family group is not known and may be another area for future research. Lack of assessment of treatment fidelity was also a limitation of the study design. Funding constraints also prevented collection of the full range of dependent measures at the 18-month follow-up, so that only relapse and employment data were explored.

Conclusions

It is possible to significantly improve clinical outcomes for consumers in a real-life clinical situation with relatively few additional resources by integrating family intervention into routine clinical practice. This study provided a strong basis for the continued use and evaluation of the multiple-family group approach with migrant families when specific cultural modifications are made. The data trends suggest that future exploration of family interventions with people from a range of cultural backgrounds and immigrant groups may be approached with cautious optimism. The observed variability in the impact of family treatment on symptom profiles warrants further investigation. Studies could explore the effects on specific treatment outcomes of variation in duration of treatment, group content, and relative emphasis on different problem or symptom areas.

Acknowledgments

The project was principally funded by grant 1997-0219 from the Victorian Health Promotion Foundation. The authors thank Henry Jackson, Ph.D., Margaret Leggatt, Ph.D., and Paul Maruff, Ph.D.

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