Editorial
On quality of mental health care: Is Australia getting it wrong?
Professor Graham Martin

In being Clinical Director of a large Child and Youth Mental Health Service, there are constant nagging questions to be considered about the quality of care we provide every day. Are the right clients being seen? How many potential clients are there out in the community with similar problems to those that are brought to us, who just cannot get to care? Perhaps no-one has recognised there is a problem, the professionals concerned (if there are any) never thought to seek further consultation or referral, everyone was put off by the waiting lists, the distances to be covered are just too long. Are there groups of clients who do not get to see us and really should? Are there groups of clients for whom we do not have the skills? Are the clinical assessments accurately telling us what needs to be done to change situations to the client family’s satisfaction? Do clinicians accurately diagnose the collection of problems? Does the right therapy exist in our service for the specific set of problems presented to us? Are we training the right set of therapeutic skills? Are clinicians able to utilise the skills we are training? What actually does go on in the clinical consulting room?

We do try to address many of these issues. In our service we have had the good fortune to gain specific funding, for instance, to set up community outreach services for young people involved in the juvenile justice system (CYFOS), we have a clinical team working in the local Youth Detention Centre, we have a collaborative program with the Drug and Alcohol service (MHATODS). We provide good orientation programs for new staff, and regular staff update sessions – often with responsibility for organising the presentation sessions being taken by community teams themselves (‘in teaching we learn’). We have ongoing focused therapy training for various groups, and are planning update training courses in specific modalities such as Interpersonal Therapy. But I still have nagging questions about what actually does go on in the clinical consulting room?

Of course we have clinical accountability. Regular supervision occurs with senior practitioners in the service, and some form of supervision is available in an ongoing manner for all staff. Even with new consultant psychiatrists, who theoretically have ‘jumped through all the hoops to become good safe practitioners, I provide 12-18 months of what we call ‘transition to consultanthood’ – which allows us to talk about clinical, interpersonal and administrative issues, and gives me both insight into the consultant, and some security in their ability to manage. In addition to supervision, we have an electronic record keeping system (which does occasionally provide feedback), and we have written notes, we have regular team discussions about both new and follow-up cases, and of course we have the Health of the Nation Outcome Scales for Children and Adolescents and the Strengths and Difficulties Questionnaires, and other scales to tell us about our outcomes. But I still have nagging questions about what actually does go on in the clinical consulting room?

Contact: Professor Graham Martin, Director Child and Adolescent Psychiatry, University of Queensland, Brisbane, Australia. graham.martin@uq.edu.au
Published by: Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) – www.auseinet.com/journal
Do we provide enough time, and in particular thinking time, for our clinicians? Are they accurate enough in the response to the sequence of minute issues brought up in sessions, voice inflections, body language, and other indicators of therapeutic alliance? In applying sometimes formulaic therapeutic interventions are they still able to assist the young client, and/or their family, to gain a sense of meaning? When we apply evidence-based practice to the consulting room and the individual case do we really get to the essence of solving clinical problems? What is the evidence for that? Are we really being effective and efficient if certain clients keep on coming back? This is a real question based on a real case. Recently I did an internal review of a long-term case with a young person with a mix of intellectual, speech and conduct problems in the context of a separated mother with bipolar disorder, and a dysfunctional extended family. Several therapists had spent about two years each on the set of problems not to mention the inpatient admissions, the case review sessions, and the ongoing angst about the emerging diagnosis. The therapists had been caring and supportive to the family, and certainly responded to all the crises in an appropriate manner. But the case had been part of our service for 11 years. Is that an efficient use of time and very scarce resources? Had we actually achieved any change? By what yardstick do we measure these things?

As a service we have adopted the complexities of promotion, prevention and early intervention (PPEI) - we are ‘early adopters’ -, and allocated considerable resources to training clinicians in somewhat new ways of thinking, as well as setting up specific programs. As examples, we now have a very active (and prize winning) program for children of parents with mental illness (KOPING), a superb collaborative program for the families of young children with multiple problems (Future Families), and a wide range of regular education programs for professionals in the community (which attract large crowds). Like all clinicians, ours moaned about the new national direction in the Second Mental Health Strategy (Oh no, not something else we have no time to do! On top of everything else...!). Now there is an integration of some of the ideas about mental health promotion not just being a Public Health program, but able to be utilised in the consulting room. But then is it? There I go again with that hard question about what actually does go on in the clinical consulting room?

The question is not just academic, or the foible of an ageing child psychiatrist. We have two circumstances where new money is being supplied to develop new teams. In response to the very adverse report of the CMC enquiry, recurrent funding has been supplied to the Department of Child Safety to buy in clinical services for the (often very troubled) young people under their care. Across Queensland (and based on equity of access) there will be nine new teams of about ten staff, with a strong focus on clinicians, a half-time psychiatrist position for each team, an a half-time evaluation position for each team. Such riches! Leaving aside the question of where we suddenly get 90 staff from, the central question is how do you respond to a challenge like this? How do we ensure that we have the skilled staff to do what may be very complex clinical work with the particular socio-economically deprived group represented? How do you develop a system of access and care to ensure that we not only do a good job for the young people and their families or foster families, but are also seen to be responsive and doing a good job for the Department of Community Services (DoCS). Funnily enough we began back to front looking at the demands of outcomes at the clinical level, the service level, the interagency level and the Ministerial level. Evaluation has driven the clinical and administrative process! This led us to provide clear parameters of functioning at all of the levels. But I am still pondering that essential question, and it has seemed to me through all of the meetings we have had, all of those clinical questions are brought into sharp relief. Well, of course, we could just supply a group of trained clinicians and sort of do ‘more of the same’, but we have felt this to be a fantastic opportunity to apply our best consensus knowledge, draw on evidence-based practice, and try to do the very best we can. It could, of course end up over time with us all just doing ‘more of the same’, but that would be a great shame.

Another fantastic opportunity, and one more relevant to this journal, and the processes that Auseinet has tried to drive in Australia, is that
provided by North Lakes, a new comprehensive suburb 35 minutes north of Brisbane. Again with new recurrent money to build a Child and Youth Mental Health Service from the ground up (alongside community health and adult mental health), we are being challenged to think through what we need to consider to build the very best service we can. We are using the PPEI framework and, in a series of workshops with broad representation from services and the community, looking at the kinds of collaboration we will need to ensure we can both manage the preventive frame (from Universal through Selective to Indicated approaches) as well as the pressure of clinical work in what will become a catchment of 150,000 people with a wide range of socio-economic backgrounds. And of course we must make it sustainable. I am not yet sure what we will end up with, but even with my long-term commitment to PPEI, I will have to ask all of those difficult clinical questions.

An emerging answer to both the DoCS and the North Lakes situations seems to relate to the quality of the clinicians we are able to employ. If we are looking for effectiveness and efficiency, with commitment to the clinical outcomes as well as provision of a sense of meaning for the young people and the families we see, then there is no substitute for highly trained, well qualified, experienced, and well supervised clinicians who have an ongoing fascination for the clinical process. One of the conundrums here is that if the clinicians are genuinely effective and efficient, then they will have time for reflection, and time to consider the wider range of programs necessary in a new suburb. If we are only able to employ young clinicians, or those who left a previous service because they were disaffected with the apparent daily clinical overload, we may well be in trouble.

So this brings me to the issue of quality and some of the pitfalls that may be emerging in Australia. There are more than rumours that nurse training may be reduced in universities to increase the numbers of available nurses and replenish the obvious need in our hospitals and the community. At one level you can see the logic, but does shorter training by implication mean that these people will come with fewer skills, and less experience? There is also more than just talk that the current graduate medical degree may be shortened to a two year graduate degree. Again you can see the logic given Australia is currently so short of primary care and specialist doctors. But does less training, and less time to reflect on a professional career, less time to weed out those who perhaps should not be practicing in one of the helping professions, mean that we get professionals who are less effective, less efficient, and more prone to give up under the sometimes intense pressures with which we all at times have to struggle. Leaving aside some of the current debates about professional incompetence (as if we can leave them aside with all the international media coverage) what is it about training that might protect professionals from burnout? Personally, I believe it is something to do with quality of training, the building of commitment and a passion for what it is that we do, a thorough knowledge of what it means to be ethical, and learning how to be both effective and efficient. Sometimes surviving a lengthy and somewhat arduous training is important to the quality of the end result.

Which brings me to the final area I want to discuss. I have recently had the privilege to bring together a Consortium to complete an application for the proposed National Youth Mental Health Foundation (I am sure we are one of many groups to tender). Again this is a fantastic opportunity to address issues to do with literacy in young people and access for those young people with mental health problems. It is also a fantastic opportunity to provide training to general practitioners, and allied health professionals who may have the opportunity to work in primary care with GPs. It is also an opportunity to consider carefully the models that can be promoted, improved, or developed as initiatives to improve service access for young people. And the stated framework is one of PPEI! Hurrah!

But there are some questions emerging for me about the program. It is three and a half years of funding, and therefore whoever gains the large grant will have the enormous task of building in some sort of sustainability to the Foundation and its programs. Another issue is that there are already many groups – State and Territory based as well as national – whose work already impinges on the area. Somehow all of these
groups will have to be drawn together – a ‘joining of the dots’ I have heard it called. But the question in mind is about quality. The pointy end of this whole process is that young people deserve the very best of care that can be made available, which includes the quality of engagement, the optimum development of a therapeutic alliance, and the ability to do effective, efficient and meaningful therapy to solve the problems presented by the young person. I have been a general practitioner, and we have recently been working with general practitioners to provide an audit of their ability to recognise mental health problems. What emerged from this process was the tremendous pressure that GPs are under to provide a rapid throughput of casework. We are asking a lot of GPs, even those committed to mental health issues who have trained through the Better Outcomes in Mental Health Care program, to expect that they will be able to make time to do a quality job. And coming back to my repeated question, how will we be able to assess just what occurs in the consulting room? I wish the successful tenderers every success in developing this massive venture. At the pointy end, the challenge may be to develop the quality of general practice mental health care and allied health care in primary care, or the quality of care in some innovative youth access programs. But we still must continue to improve access to care in dedicated mental health services and ensure that the professionals there are able to deal with the most serious of mental health issues in a timely, effective and efficient way because they are experienced, well trained and well supervised. The focus of the exercise really is the whole system and its quality.

Which brings me finally to this issue of AeJAMH, where it will be abundantly clear that we do have some very good quality articles. We have two thoughtful guest editorials which record the changes occurring in our mental health system. Lynne Freidli reflects on the launch of the UK National Framework for Improving Mental Health and Well-being. She notes that ‘tackling discrimination and social exclusion have received a stronger focus than promoting mental health’ thus far in England, and that this fine focus may have stopped the wider lens view of what factors in a society may be toxic to mental health and well-being. There are high hopes that there will be a refocusing on ‘how we live’, and its impact on ‘care of children, care of the self and social relationships’. Jennie Parham reflects on the recent Dublin conference ‘Mental Health Promotion: Going from Strength to Strength’, and her discussions with colleagues in the UK, who believe that Australia may be 10 years ahead in the development of preventive activity in mental health. Jennie rightly asks why we in Australia may not feel that this is so. After reviewing the current status in Europe, and then in Australia, she examines the ‘report card’ for Australia against a recent WHO framework document, noting that the complexity of our federation makes for difficulty in the translation of national policy into practice, concluding that considerable effort is still necessary to maintain the momentum we have with regard to mental health and its promotion against the pressure of the need for clinical service.

Two articles (Reid et al. and Maybery et al.) address the two sides of the care coin. Darryl Maybery and colleagues’ research on children of parents with a mental illness, reminds us of the need to develop and improve support and coping mechanisms such as ‘problem focused coping, developing adaptive cognitive styles, fostering social skills with peers and siblings’. However the children in the research also provide us with a challenge - to enhance the natural supports of the child, that is the peer group, especially in times of crisis when a parent is newly ill.

Joanne Reid and colleagues report on ‘the other side of the coin’ in a timely, challenging article based on phenomenological research on the needs of parents of adult children with mental illness. In recent years, we have heard so much about the children of parents with mental illness, that this is a refreshing reminder of a contrasting area of need. In focusing on psychoeducation, they address educational needs, barriers to accessing information and support, and other unmet carer needs, including the need for managing stress and emotional needs. My own experience is of being bailed up after Rotary forums where desperate parents frequently bewail the system which attempts to lock them out of the information system while expecting them to provide ongoing support and care. This paper is a timely reminder to think again.
Janice Chesters and colleagues explore the perspectives of fifteen residents about a supported housing program for people recovering from low prevalence mental health disorders, and address the importance of such accommodation in the community. The semi-structured interviews provide a sometimes poignant richness of comment. Overall, supported accommodation provides a treatment and living place, but more than that a venue in which to put together the right ingredients to help facilitate recovery.

Phillippa Farrell and Trish Travers report on Healthy Start, a program designed to build the capacity of the childcare workforce to promote the mental health of children. The research demonstrated increased awareness of risk and protective factors and referral sources, as well as levels of confidence in discussing mental health issues with parents, immediately after the training, but this was sadly not sustained over time. The crucial role of childcare workers, the needs they have for education, and the lessons learned from the program are explored.

Sarah Stewart provides a welcome exploration of how culture may mediate the inter-relationship between interpersonal trauma and suicide. In this very thorough review of the literature, she explores abuse, domestic violence and culture, considers these across a number of specific cultures, and notes there are gaps in our understandings of how culture mediates the inter-relationship between interpersonal violence and suicide. Sarah rightly challenges our current understandings about suicide and takes policy to task on the issue of domestic violence.

Finally, in a supplement to this issue of AeJAMH, Geoff Waghorn and Chris Lloyd provide an in-depth exploration of employment and mental illness, looking at education and employment opportunities as human rights, the disease burden of mental illness, and the inter-relationship of specific illness and employment. This comprehensive study goes on to look at the implications for the psychiatric disability support sector, and the development of policy. They comment: ‘although a range of promising vocational services and programs are available in Australia, the forms in which these are provided are the result of service systems evolving over time’. They then recommend six priorities for policy makers and funding providers which emerge from the study.