



Response to the Independent Review of new arrangements for the delivery of Mental Health and Drug Treatment Services

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**Jesuit
Social Services**
Building a Just Society

Introduction

Jesuit Social Services welcomes the opportunity to provide this response to the Independent Review of new arrangements for the delivery of Mental Health and Drug Treatment Services. Our comments and concerns draw from our experience of over 38 years working directly with people with complex needs with mental health and substance misuse issues.

Jesuit Social Services provides a number of services in which staff engage with MHCSS and drug and alcohol services. These include our specialist dual diagnosis counselling and outreach service, Connexions; the co-located Artful Dodgers Studio providing arts and music programs for young people with mental health issues; our housing programs working with young people in contact with the justice system; and our youth and adult justice programs. These comments draw on the experiences of staff in these programs; and are specific, where relevant, to the different issues experienced by our young, and adult participants. Many Jesuit Social Services participants primarily engage with youth drug and alcohol services, or are engaged in alcohol and drug programs mandated by court processes.

Jesuit Social Services has previously expressed serious concerns about the expected impact of the new mental health arrangements on people with more complex needs, particularly young people. The implementation process has revealed that these concerns were well founded. We also have similar concerns about the impact of recommissioning of adult drug and alcohol services on access to support for people with more complex needs.

Our comments primarily draw on our direct experience and where that experience is considerable and consistent across many participants. Accordingly our Submission focusses on issues arising from those areas; and is mostly concerned with the impact of recommissioning of mental health community support services (MHCSS). We have however also commented on AOD services where applicable. We strongly endorse the concerns expressed on recommissioning of adult drug and alcohol services by the sector's peak body, VAADA.

**We have changed the names of all people described in the included case studies.*

Intake and assessment service function

While the intent of the reform objectives around intake and assessment to make services 'easier to find and access' was worthy, in practice the drive to make the system 'simpler' has compromised access to services for many people with mental illness.

What have been the main impacts of the new arrangements on ease of access for consumers?

The new arrangements have created a significant and often insurmountable barrier to access to services for many people with whom we work. These barriers include overlapping issues around eligibility, as well as issues around unsuitable processes.

Eligibility

Particular access challenges arise for young people in setting the threshold for Psychiatric Disability as 'permanent or likely to be permanent' impairment. These include:

- Mental health problems are commonly first diagnosed in adolescence or early adulthood, and consequently it is unlikely – and potentially undesirable – that early symptoms would be considered permanent, or likely to be permanent. Nor, potentially,

has sufficient time elapsed since diagnosis to meet this criteria. During the process of this review we have learnt from some providers that they accept young people for support with high prevalence conditions such as anxiety and depression, and that they will accept a young person who has had a diagnosed mental health condition for over six months. These are positive modifications of the criteria – but need to be generally communicated to referring agencies to more usefully enable eligible young people to access support. It is also not clear if this describes the practice of a single provider, or is general practice.

- Many young people experiencing problems with their mental health do not recognise them as mental health problems and/or actively resist defining their issues as a mental health problem. Our participant Minoo* is one example among many young people who were not initially engaged around mental health, highlighting the importance of a diversity of soft entry points to mental health care and support.

Minoo* is South Sudanese and 21 years old. She began coming into the Artful Dodgers studio in March 2015 to pursue her interest in making rap music, and developed a rapport the Connexions case worker based at the studio.

Connexions linked her to a dual diagnosis AOD/ mental health counsellor at Connexions, who together with Kate visited her at home after some initial contact in the studio, to establish and develop rapport, and then moved appointments to the studio/ Connexions.

Initially, Minoo did not identify with having any mental health problems - or in fact knowledge of what mental health was, or the need for any support services (consistent with her cultural background). She was however presenting with symptoms of depression, PTSD and alcohol dependence.

During her initial contact she attended alcohol impaired, had regular involvement with the police and outstanding legal matters, and was not receptive to further referral to services.

In July, Minoo completed a 7 day detox and has now been sober for 2 ½ weeks, which is the first time she has not consumed alcohol for more than a few days this year. She has attended all of her court dates, and, supported by Kate, has submitted a family court application to gain legal custody of her son who was last year taken interstate by his grandfather. She is also continuing to work on her song writing and music.

- Since recommissioning, participants can no longer access MHCSS without a recent mental health diagnosis. This presents direct practical problems for people with more complex needs as the process of obtaining a diagnosis can be administratively complex, and involves scheduling, keeping and often paying for multiple appointments. Jesuit Social Services has also had a number of experiences in which the timing and process of obtaining a diagnosis compromises participants' recovery journey. Rita's* experience below is one such example.

Rita* is a 24 year old woman referred to Connexions by Jesuit Social Services staff who were working with her younger brother and came to recognise her extreme vulnerability. Rita is a survivor of severe abuse and neglect.

Initial assessment revealed symptoms of complex Post-Traumatic Stress Disorder and early neglect (owed to drug usage within her family of origin); anxiety and subsequent social isolation (some symptoms of Agoraphobia); issues of grief and loss (relating to

the premature death of her father); and recent experiences of domestic violence by her brother and substance addiction.

Rita is long-term unemployed; has had limited educational opportunities (with reports of dyslexia symptoms that were ignored in both primary and high school); and a chronic history of dysfunctional relationships within her family (from whom she was mostly estranged).

Rita engaged in dual-diagnosis counselling with Connexions, and was also supported to connect with NEAMI, who provided some intensive outreach support and partnered with Connexions in case coordination. As a result of this engagement, Rita was successfully referred to housing, employment and education services.

After a period engaging with this support, Rita was open to considering more intensive engagement with mental health services but to do so required a psychiatric assessment. Her care team organised her an appointment with a psychiatrist, and funding to pay for it, and Rita was accompanied to her psychiatric assessment by her NEAMI outreach worker. During her assessment the psychiatrist:

- questioned her directly about her traumatic experiences and repeatedly demanded details
- openly expressed doubts about her experiences, and made judgemental comments about her subsequent conduct
- had a generally careless and insensitive attitude, and
- made a series of diagnoses that made Rita feel stigmatised.

After this experience, Rita's trauma related symptoms (including intrusive memories and nightmares) and substance use increased, and she disengaged from her care team who she blamed for encouraging her to participate in the assessment.

Process

Research and practice evidence highlights the importance of the following elements in working with young people who have multiple and complex needs: the centrality of relationships, use of a strengths-based approach, a whole of needs approach, a "no wrong door" model of access to health and social services, a flexible approach to service delivery, and service user empowerment.^{1 2} These elements are equally critical for adults with complex needs.

The inability of the intake process to enable relationship development to precede assessment is a fundamental problem for people with complex needs in the recommissioned service model. The phone based intake process also present practical challenges.

Since the recommissioning participants must call themselves, and then continue the assessment when they receive a call back. Our participants often lose or 'hock' their phones, or have no credit or charge, and can quickly become unreachable. They are likely to not be 'ready' for the assessment when they are called: they may be in a public place, with friends, drug affected, or otherwise not in the right state of mind to describe their mental health problems.

¹ Rankin, Jennifer & Raegan, Sue (2004). *Meeting Complex Needs; the future of social care.*

² Parker, R 2009, 'Helping families with complex needs: Integration of the Strength to Strength and Resources for Adolescents and Parents programs', *Family Relationships Quarterly*, No. 14.

Even where a participant is with a worker when this assessment takes place, the worker only hears the participant's end of the discussion so is unable to assist in the interpretation of questions or in a debrief about what was asked. As a consequence of these barriers, many participants do not access the mental health support they need.

These issues around the process of phone-based intake are similarly a barrier to accessing services for adults with more complex needs. Prior to recommissioning, Jesuit Social Services adult justice staff would schedule an assessment for a participant needing mental health support, and provide a reminder or direct assistance for them to get to the appointment. Commonly, adult justice staff would also accompany the person to the appointment, providing encouragement and support beforehand around the questions they would be likely to be asked, assistance to understand questions during the appointment if necessary, and debriefing afterwards if the assessment was confusing for the participant or raised difficult issues.

The challenges of the phone based intake process are exacerbated by the waiting period that usually follows assessment, during which services are very likely to lose contact with participants with complex needs for the practical reasons described above.

Successful models of work with people with more complex needs involve activities that create space for relationships to develop and outreach and/ or 'engagement hub' capacity. Intake assessments must necessarily be conducted by staff who have developed relationships with participants.

The intake and assessment process presents particular challenges for people in prison. As one senior practitioner working in our Reconnect program notes:

In my experience, mental health and AOD services are now harder for participants to access; it is particularly difficult to have these set up whilst a participant is still in prison. Our participants need to be transferred from an initial intake catchment dependent on where they are imprisoned to the catchment where they will be living post release. This is particularly difficult if a client may have a region that they want to return to post release, but still have no confirmed address.

Mental health intake services in particular are unfamiliar with prison processes in terms of arranging assessments, and often our support workers need to advocate for phone link assessments to take place or arrange these in custody visits, particularly for clients referred to the mental health residential rehabs.

When people leaving prison have been referred for outreach only support, often agencies will not be allocated from intake until after the person's release. This is generally too late because we are working to establish a care team for someone prior to release, and it would be preferable to have a service allocated at that time.

I have found the referral process to also be very time consuming and require information on forms that can be hard to understand, and which requires information that cannot be obtained from prison support staff due to Justice Health confidentiality constraints. For people in prison who are not receiving transitional support from an agency like us, I can only imagine that this pathway would be incredibly difficult to navigate for people who aren't receiving case management pre-release.

Referrals for AOD assessments for long term residential rehab is similarly difficult and hard for someone in custody. Intake agencies are similarly unsure of the referral pathways and processes for someone leaving prison. And once referrals have been

sent through to agencies, such as Odyssey House, after the intake stage, the agencies require information about participants that is almost impossible to obtain because of Justice Health release constraints or lack of cooperation from prison medical services (eg: being too busy).

What have been the main impacts of the new arrangements on ease of making referrals?

Aside from the issues around eligibility noted above, the new arrangements have made referrals more difficult as workers can only provide information about where a participant can go to seek a service, but cannot facilitate their access.

A more effective process would enable our staff to complete the assessment against a common criteria; preventing the participant from having to repeat their story again, and enabling a staff member who has developed some relationship with the person needing support to capture the relevant information.

Is there adequate support and monitoring of consumers who are waiting to access services?

It would appear that support and monitoring of consumers who are waiting to access services is generally limited to occasional 'check in' phone calls. While it would seem that some modifications have developed in the new model, including some instances of intake and assessment being conducted face to face, and of young people (such as Rita - see above) receiving some support during the waiting period; these appears to be exceptions, rather than standard practice; and do not address substantive issues with eligibility and the absence of capacity for intake workers to develop a relationship prior to formal assessment.

The general lack of adequate monitoring and support during the waiting period raises some serious concerns as the intake and assessment process explores challenging personal issues and can create trauma and/ or heighten people's mental health problems. With contact with the person limited to phone contact this presents a risk that a young person is unsupported through the experience, and may drop out of contact if they lose their phone, are out of charge or can't afford to purchase phone credit.

What are the priority changes that would improve the functioning of the intake and assessment service function? How should these priority changes be implemented?

The current model presents an extraordinary barrier to access for people with more complex needs. In order to create a more seamless experience for people needing specialist mental health support, a 'no wrong door' approach is needed that builds capacity for initial intake and assessment into the services that people are already accessing and integrates rather than separates the two functions. It should be delivered in a manner which encourages and support participants to access the services they need in a socially inclusive, acceptable and welcoming mode of service. Intake and assessment functions therefore need to be built into frontline services including homelessness services, community mental health, youth services, and specialist services such as Jesuit Social Services justice, and Connexions/ Artful Dodgers programs.

This should be complemented by the capacity for people to 'walk in' to provider agencies to go through the process of intake and assessment face to face.

Programs are also needed that are specifically focussed on engaging people with mental health problems in meaningful activity that supports their social inclusion.

Service delivery

Are the policy objectives for service delivery under the new arrangements appropriate?

The policy objectives omit critical dimensions that are essential to mental health recovery, including:

- creating opportunities for social inclusion and building a sense of community around a person, and
- creating opportunities for meaningful engagement.

These dimensions should be explicitly recognised in the service model. Many people with mental illness, particularly those with more complex needs, are socially isolated, unemployed and lack avenues for meaningful activity. The boredom and loneliness this creates is known to have a corrosive effect on people's mental health; exacerbating existing mental health and substance misuse problems. Jesuit Social Services has worked to address this social isolation by creating a welcoming space in which people with mental illness can engage in activity that builds on their strengths, as have other organisations, such as St Marys House of Welcome. This non-clinical strengths-based approach has had demonstrably extremely positive impacts on people's mental health, enabling young people to develop their identity as sense of self-worth as an artist or musician – and not just as a 'drug user', or 'homeless person'.

It has also become clear that the objective 'clients will access and remain engaged with the range of other health, human services and social supports they need' in practice extends only to referrals to other providers, forcing people to be engaged with a different provider for each dimension of need. This siloing of care has been a major and significant flaw in the new arrangements. This objective should instead reflect the need for 'clients to receive services that are integrated with other health, human services and social supports; and which provide an holistic approach'.

The reform process also had a clear objective to provide participants with choice of programs and providers. In practice, the reform is delivering neither; as long waiting lists force people to 'choose' the provider with the smallest list; and the narrowing of the service offering forces people to settle for the 'cookie cutter' approach as they no longer have the option for services that provide social engagement or meaningful activity.

What have been the main impacts of the new arrangements for service delivery on person-centred care?

While the principle of person-centred practice is implied in the reform objective of 'support that is individually tailored' the implementation has revealed that in practice this simply means participants have the option of selecting from a narrow menu of unitised 'cookie cutter' interventions. For many people, including young people, people with more complex needs, and people from diverse cultural backgrounds, this is likely to mean that a service relevant to *their* needs will not be available. This represents an inherent contradiction between the original policy objectives and the service design and implementation.

One common issue that arises in our experience is the limitation in the flexibility and intensiveness of support provided. Helen* is one example of a participant needing more flexible and intensive support than is provided by MHCSS.

One participant at Connexions is supported with intensive outreach counselling. Helen* is a 24 year old woman who suffers from significant anxiety, panic and depression. She has fortnightly support from a Neami worker, who made the referral to Connexions so she could receive counselling in her home. Helen has previously engaged with Headspace and Area Mental Health, but disengaged with them due to her anxiety and panic - and was then discharged from their service for not making scheduled appointments.

After regular appointments in her home, where she spends the majority of her time as a consequence of her anxiety, panic and agoraphobia, Connexions encouraged Helen to move some sessions out into the community - in the park near her home. Together, they are working towards engaging with Artful Dodgers, as Helen is musically and artistically interested and talented.

This progress was able to be achieved because of the flexibility of the service model, enabling Connexions to invest time in building rapport and trust with Helen in her home.

This contradiction is also apparent in the way the service design has siloed mental health care into a separate stream of support from other dimensions of people's lives and from other services that provide support, including drug and alcohol treatment.

More effective person-centred care would be possible if services were better integrated into the broader service system rather than being siloed as a completely separate stream. Specialist services are also needed to address the particular needs of, and provide choice for: young people, Aboriginal people, people with CALD backgrounds, and people with complex co-morbidity issues.

What have been the main impacts of the new arrangements for service delivery on recovery-oriented practice and supporting self-management?

The new arrangements seem to have had some positive outcomes in establishing the centrality of recovery oriented practice and supporting self-management. While we continue to be concerned that services are not delivering the necessary support to the most vulnerable clients, we recognise that for many people the new arrangements may work well.

What have been the main impacts of the new arrangements for service delivery on services relevant to the needs of consumers?

Jesuit Social Services is particularly concerned that services are not meeting the needs of young people with complex needs, adults with more complex needs and people from Aboriginal or CALD backgrounds.

Research into effective work with young people with more complex needs, as well as our own experience, indicates clearly:

- that this cohort commonly have relatively chaotic lives and do not successfully engage with appointment-based supports
- that development of relationships is an essential pre-cursor to more formal therapeutic engagement

- that young people are not generally comfortable participating in group work alongside adult participants
- that young people's drug abuse, family relationships, housing and other issues need to be addressed alongside mental health issues, and
- that young people's mental health is significantly enhanced by support that enhances their social inclusion and engages them in meaningful activity.

Further young Aboriginal people and young people from CALD backgrounds need support that is culturally safe and sensitive to their cultural context.

Given the very limited capacity of the new arrangements to undertake outreach; the absence of means for young people to develop a relationship with workers during an 'engagement phase'; the lack of youth specific or culturally specific programs; the absence of a focus on creating community or opportunities for meaningful activity, and the separation of therapeutic care from responses addressing other issues we do not believe young people with complex needs are being provided with a service that can effectively support their recovery.

Similarly we are concerned that older people with complex needs alongside their mental illness are also not receiving services that meet their needs. Many older people with mental illness and complex needs are extremely poor, isolated and excluded from community life. Programs, such as St Marys House of Welcome, which provide a sense of community, engagement, acceptance, and practical assistance such as nutritious meals, are far more likely to enhance their mental health than a counsellor.

To what extent do the services provided help consumers improve their daily living skills and achieve improved quality of life?

As noted in other sections, the new arrangements may have enhanced services for many service users, but contain serious gaps for people with more complex needs.

Are consumers who face the greatest vulnerability receiving the services that address their needs?

For the reasons described above including the formidable barriers to entry imposed by the intake and assessment arrangements; the separation of support from the services with which the most vulnerable community members engage; and the narrowly defined unitised mode of delivery of support the new arrangements effectively exclude more vulnerable service users.

What are the priority changes that would improve service delivery? How should the priority changes be implemented?

A fundamental redesign of the intake and assessment process is a critical priority. This intake and assessment function needs to be integrated into services that are engaging and supporting people with mental illness and complex needs.

A further priority is the inclusion of meaningful engagement and social inclusion as critical dimensions of recovery and consequently as funded activities. To enable a real choice for people with mental illness and complex needs, programs providing these activities need to be funded in both mainstream and the specialist services that already engage people with more complex needs.

Holistic models should particularly focus on services that engage people who are homeless, as well as specialist services working with currently excluded cohorts, including Aboriginal people, people from CALD backgrounds, and young people, and people with complex co-morbidity issues.

Further reform is also needed to address the lack of early intervention and long waiting lists for service among people needing mental health care.

Service relationships

One consequence of the siloing of mental health care into a separate stream is that general information about services available, as well as updates and adaptations to the model no longer flow to services not within the mental health net. A consequence of this is that we have only become aware of some ways in which services have developed since participating in discussions as part of this consultation process.

However, at a local level the Yarra Mental Health Alliance has created space for sharing and collaboration and for positive information flows. We have particularly welcomed being informed of the availability of spaces in residential care.

We have also had positive experiences of worker to worker collaboration around specific clients.

What are the priority changes that would improve service delivery? How should the priority changes be implemented?

Mechanisms are needed to share information more broadly with the sector, beyond the providers delivering mental health care.

It should also be noted that while service coordination is important to link across supports that need to be provided by different workers or agencies it is often not the best approach to have different agencies responding to the different dimensions of a person's issues in isolation.

As noted above, integration of mental health supports into specialist services should deliver better outcomes for vulnerable participants than forcing their engagement in siloed care to address different dimensions of disadvantage.

Area-based service model and catchment planning

As noted above there has been some worthwhile collaboration at the local level through the Yarra Mental Health Alliance, but at a broader level it is not clear how the area based objectives are progressing.

Given that in many areas, the recommissioning process defunded many organisations with strong local presences and established connections in favour of large organisations without any local knowledge, it would seem that there is much ground to make up to have effective service coordination at an area level.

Workforce

Jesuit Social Services has been concerned that many very experienced practitioners left the sector through the recommissioning process and have been replaced by less skilled and experienced practitioners, particularly in intake and assessment. This is unlikely to change

as the intake and assessment role now involves following a script over the phone, effectively deskilling the task and providing extremely poor job satisfaction.

The loss of skilled staff also extends to case management roles and is inevitably compounding the structural problems, noted above, in working with more complex participants.