Demystifying the Mental Health Service System

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What is mental illness?

According to the Australian Government Department of Health and Ageing (2007), a mental illness is a health problem that significantly affects how a person

- Feels
- Thinks
- Behaves
- Interacts with other people

And is diagnosed according to standardised criteria.
Findings from the Australian *National Survey of Mental Health and Wellbeing* (2007) show that almost half of the population (45.5%) met the criteria for a mental disorder at some stage in their entire lifetime. (These figures included high prevalence disorders such as depression and anxiety as well as substance use disorders).

Mental disorders are experienced with different levels of severity and low prevalence disorders, often referred to as serious mental illness, can be particularly disabling (Slade, Johnston, Oakley Brown, Andrews, & Whiteford, 2009).
Victoria’s Mental Health Service System Components

- Child and adolescent mental health services (0-18 years)
- Adult specialist mental health services (16-64 years)
- Aged person’s mental health services (65+ years)
- Psychiatric disability rehabilitation and support services
- State wide specialist services
  - Forensicare
  - Personality disorder service (Spectrum)
  - Community brain disorders assessment and treatment
  - Mother-baby services
  - Eating disorder services
  - Koori (Aboriginal health) services
  - Dual disability service
  - Early psychosis prevention and treatment centre (EPPIC)
  - Victorian Transcultural Psychiatry Unit (VTPU)
Adult specialist mental health services are aimed primarily at people with serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder.

- Crisis Assessment and Treatment Teams
- Mobile Support and Treatment Teams
- Continuing care, clinical and consultancy
- Clinical residential rehabilitation services (Community Care Units)
- Prevention and Recovery Care services
- Early intervention services
- Early Psychosis Program
- Carer and consumer consultants
- Family where parents have a mental illness program
- Acute inpatient services
- Consultation and liaison services
- Secure extended care inpatient services
- Homeless outreach service
Aged Persons Mental Health Services

Primarily for people with a long-standing mental illness who are now over 65 years of age, or who have developed functional illnesses such as depression and psychosis in later life. They also provide services for people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

- Aged persons assessment and treatment services
- APMH Nursing Homes and Hostels
- Acute inpatient services
- Carer and consumer consultants
- Consultation and liaison services
The non-government PDRSS are a core component of specialist mental health services complementing clinical mental health services.

PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person’s daily activities and the social disadvantage resulting from illness. They work within a recovery and empowerment model to maximise people’s opportunities to live successfully in the community.

Psychiatric disability support services are aimed at people with serious mental illness and associated significant psychiatric disability. Services cater primarily for people aged between 16 and 64 years. The precise eligibility criteria will depend on the type of service or program being offered. Consumers receiving case management services from the public mental health service who are referred by the service are automatically eligible for support from the PDRSS.
Your local services

- St Vincent’s Aged Psychiatry: one of 17 Aged Psychiatry Services
- St Vincent’s Mental Health: one of 21 adult mental health services

There is a variation based on local circumstances as to how each of the 17 services operate:

- Some provide a CDAMS (Cognitive Dementia and Memory Service) and Psychiatric Extended Care Clinics
- In some areas where there are less acute in-patient beds and it is clinically possible a 7 day hospital in the home service is provided
- In some rural areas clinicians are located away from the regional service and provide part of a broader community health response
- APMH residential care in some rural settings is integrated with general medicine geriatric care
- Some services provide intensive specialist behaviour management services such as Resident Support Programs (RSP)
Mental Health assessment, treatment and rehabilitation services to persons 65 years and over who have or are thought to have a serious mental illness

Ensure 24 hour emergency access for clients through a combination of direct access to the community team during regular business hours with “after hours” coverage provided by adult mental health services through a central psychiatric triage number.

We use an integrated multidisciplinary approach to service delivery, training, education and research

- Manager and Admin Staff
- Consultant Psychiatrists and Psychiatric Registrars
- Nursing and allied health
  - Nurses
  - Social Workers
  - Occupational Therapists
  - Psychologists
- Allied health assistants
Referrals to our service can occur through:

- General practitioners
- Other service agencies
- Residential services
- Family/significant others
- Police & Emergency Services
- Hospitals
- Private psychiatrists
- Self

Referral Process

Area Mental Health Service Triage

Duty worker

Screening

Intake

Delegation

Assessment

Case Management

Case Closure

Crisis Response

Referred on or no further action

Referred to alternative service or no further action

Referred to care of General Practitioner and/or alternative service
APATT Services

- Telephone advice and triage
- Advice, advocacy, education on mental illness and referral to other appropriate services
- Home based assessment, diagnosis, consultations treatment and case management
- Assessment prior to admission to Acute or continuing care psychiatric beds
- Residential Support Program which provides specialist input for residential care facilities to assist in managing challenging behaviours and complex care needs
Mental Health Act 1986 (MHA)

Provides the statutory framework for administering services to people who undergo treatment or care for mental illness in Victoria.

Key features of the Act are its emphasis on rights and the requirement that treatment should be provided in the least possible restrictive environment and in the least possible intrusive manner.

The Act provides that interference with the rights, privacy, dignity and self-respect of people with mental illness must be kept to the minimum necessary in the circumstances.
Review of the Victorian *Mental Health Act 1986* is occurring since May 2008 to see if the Act provide an effective legislative framework for the treatment and care of people with a serious mental illness in Victoria.

The Act is the oldest mental health law in Australia. It has been amended many times in response to specific issues to ensure it incorporates key developments in mental health policy and practice.

Each state and territory has its own mental health laws that don’t translate except in boundary areas under interstate agreement.
The Victorian Mental Health Bill

- Will establish a contemporary legal framework for compulsory mental health treatment and care by replacing the *Mental Health Act 1986* (MHA) with a new Act

- deliver a more patient centered, rights-oriented, least restrictive and recovery-focused approach to treatment and care for people with serious mental illness

- provide greater opportunity and support for patients to participate, as far as they are able, in their treatment and care

- reduce the duration and minimise use of compulsory treatment

- The review will aim to ensure that the Act appropriately protects human rights in light of the *Charter of Human Rights and Responsibilities Act 2006* (the Charter)
The 5 Criteria for Involuntary Treatment under the MHA

- The person appears to be mentally ill
- The person’s mental illness requires immediate treatment or care and that treatment or care can be obtained by admission to and detention in a psychiatric in-patient service
- The person should be admitted and detained as an involuntary patient for that person’s health or safety or for the protection of members of the public
- The person has refused or is unable to consent to the necessary treatment or care for the mental illness
- The person cannot receive adequate treatment or care for the mental illness in a manner less restrictive of that person’s freedom of decision and action
Possible mental health issue... what should you be thinking?

- When did the problem start?
- What has the person been doing to manage?
- Does the picture fit the person’s cultural beliefs?
- What type of help do you think is needed?
- Do family, local doctor, friends, support agencies or community know?
- What are they currently doing to help?
- What do you need to do about it?
- When do you call public mental health services???
When to call the APATT?

- Review of Mood Disorders
- Assessment of Suicidality
- Opinion on Delusions and Hallucinations
- Advice on significant Behavioural and Psychological Symptoms of Dementia (BPSD)
- Treatment of Mental Illness

Do first:
- Discuss intent to refer with LMO and family if possible
- Check for delirium, get LMO to do organic screen
- If in doubt, talk to the APATT duty worker prior to referring
When to call the APATT?

- *If in doubt talk it out*, with colleagues, manager etc
- Have all relevant information handy:
  
  Risk factors for visiting staff, demographics, presenting problem, social circumstances, known psychiatric or medical Hx, recent investigations/medical reviews, current medications etc
- Ring us and speak with the duty worker
- Avoid use of Mental health jargon! (that’s our job)
  
  much better to provide a brief description of what is happening, the behaviour exhibited or quote what the person has been saying to you or others, how often is this happening and what the concerns are.
Factors in assessment and care of psychiatric disorders in old age

- Medical illness and physical disabilities
- Gender
- Culture and language
- Spiritual beliefs
- Socio-economic status
- Psychiatric co morbidity
- Isolation, potential elder abuse
- Polypharmacy and higher risk of side effects
- Home supports from family and home care services
- Cognitive function if dementia is present
St Vincent’s Aged Mental Health Service Pathways

Client in need of service

Support by Academic Unit:
- Education
- Training
- Research
- Specialist Clinics

Client treated at home

Engage Medical And Home Care Services
Provide APATT Case Management

Aged Mental Health Assessment

Acute Psychiatric inpatient Assessment

Residential Support Program

DBMAS Dementia Behaviour Management Advisory Service

Residential Care Placement
- SAH (private, no bed subsidy from Govt)
- Hostels (low care, some Govt subsidy)
- Nursing Homes (high care, subsidised)
- Psychogeriatric Nursing homes (subsidised by commonwealth and state)
People from CALD backgrounds do not access mental health services at a comparable rate (Stolk, et al., 2008).

Major identified barriers include:
- Language and communication
- Lack of information regarding services
- Inappropriate use or lack of appropriate interpreters
- Cultural differences between clients and clinicians

(Australian Government, 2004; McDonald & Steel, 1997; St Vincent’s Mental Health Service & Craze Lateral Solutions, 2005).
(Multicultural Mental Health Australia, 2010c).
The reasons for this are, in all likelihood, related to a range of “service barriers and psychosocial factors in ethnic communities, contributing to presentation to mental health services... late in the course of a disorder” (Stolk, Minas, & Klimidis, 2008), rather than lower rates of mental illness in CALD communities.

Additionally, it has been noted that people from CALD backgrounds are often unaware of the range of services and supports available and very frequently misunderstood how these services operated (National Ethnic Disability Alliance (NEDA), MMHA, & Australian Mental Health Consumer Network (AMHCN) 2004).
Consumers highlighted a range of issues related to living with a mental illness including isolation from their own and the broader community, and uncertainty and frustration with the service system.

Consumers also spoke about the impact that ethnicity has on having a mental illness, particularly language difficulties encountered when seeking information.

One of the strongest themes common among all consumers was isolation and lack of community support:
Consumers identified concerns about interpreters as a major issue in accessing services.
General lack of interpreters and bilingual staff available

Perception that interpreters are often not well educated about mental health issues, resulting in consumers receiving inaccurate or confusing information.

Consumers also reported that misdiagnoses were occurring because interpreters were not relaying the appropriate information to mental health staff.

(Reality Check: Culturally Diverse Mental Health Consumers Speak Out MMHA & NEDA & AMHCN.. findings from a series of national consultations with Cultural and Linguistically Diverse mental health consumers about their needs, concerns and aspirations)
Mental Health of Migrants and Refugees

- Over a quarter of a million first generation adult Australians from culturally and linguistically diverse backgrounds are estimated to experience some form of mental disorder in a 12 month period.
- In 2001, the prevalence of mental or behavioural problems among those born in Australia (9.8%) was similar to the rate for people who were born overseas (9.8%).
- Fewer adults who spoke English at home reported experiencing a very high level of psychological distress (3.2%) compared with those who spoke a language other than English at home (5.5%).
- Hospitalisation rates for immigrants who have a mental disorder and speak a language other than English is markedly lower than that of the overall community\(^5\).
- There is substantial evidence that trauma and loss may have profound and ongoing effects on people who migrate to Australia as refugees. [http://www.mindframe-media.info](http://www.mindframe-media.info)
Access to community Aged Psychiatry services (1998 study)

Elderly CALD represented nearly half of referrals to the Service (Melbourne metropolitan service)

80% of these were assessed with an interpreter.

The referral of elderly European migrants was similar to their representation in the local population.

Matching to census data, referral rates from Asian and small ethnic communities appeared to be low. Socio-demographics showed this population were more likely to be poorly educated, have low proficiency in English and have been employed in unskilled occupations.

(Int J Geriatric Psychiatry 2002: 17)
The National Accreditation Authority for Translators and Interpreters Ltd (trading as NAATI) is the national standards and accreditation body for translators and interpreters in Australia. It is the only agency that issues accreditations for practitioners who wish to work in these professions in Australia.

On line directory of interpreters and translators


Does your interpreter have experience in mental health interpreting???
Use of Interpreters

- Conference Interpreter or Advanced Translator(Senior) (formerly known as Level 4 or 5): This is the highest level of NAATI interpreting.

- Professional Interpreter or professional translator (formerly known as Level 3): This represents the minimum level of competence for professional interpreting and is the minimum level recommended by NAATI for work in most settings, including banking, law, health, and social and community services.

- Paraprofessional Interpreter or Translator (formerly known as Level 2): This represents a level of competence in interpreting for the purpose of general conversations.
St. Vincent’s APATT clients and interpreters

- English speaking: 84%
- Require interpreter: 16%

Bar chart showing percentages of St. Vincent’s APATT clients by language:
- Italian
- Greek
- Other language*

- Italian: 45%
- Greek: 40%
- Other language*: 35%
"When dealing with clients from CALD backgrounds it is important to discover their beliefs about their illness...they can affect all aspects of care, from understanding the cause of ill-health to compliance with treatment. They may also help explain the client’s behaviours and attitudes and those of their family" (MMHA)

- Awareness of cultural and linguistic background
- Knowledge of pre-migration experience
- Post-migration experiences and current situation
- Early or late migration
- Appropriate use of interpreters
- Service tailored to needs of client and family
- Multicultural training and resource access for staff
- Ensure consumer and carer participation in planning and care
Post-traumatic stress disorder (PTSD) may arise after an extreme traumatic event. Such events may include natural disasters or war and conflict.

Prolonged stress such as being imprisoned as well as sudden horrific events can cause PTSD. Symptoms include repeated flashbacks, an inability to stop dwelling on the event, feeling of detachment/estrangement from others, sleep disturbance, and difficulty concentrating.

The incidence or severity of PTSD or PTSD-related disorders tends to decrease with time, although healing is slower in more traumatised persons and groups. Nevertheless, even in the long-term, refugees who have suffered PTSD have an increased risk of mental illness.
Delirium

Cognitive impairment in the areas of

– Consciousness
– Orientation
– Memory
– Motor coordination
– Perception
– Speech
– Thought

- This is an acute state of mental confusion, involving disorientation, and the inability to focus on information or surroundings.
Signs and symptoms of delirium are non-specific and may occur with depression, dementia and other psychotic illnesses.

In most instances underlying illness, metabolic or chemical disturbance is the cause of delirium, therefore the general practitioner will need to investigate to determine concurrent diagnoses.

Note that clients diagnosed with dementia may also be suffering from concurrent delirium and in fact having dementia places the resident at an increased risk of delirium.
Depressed Mood sustained over 2 weeks
Loss of interest or pleasure in normal activities
Decreased energy or increased fatigue

Depression is mental illness in which a person experiences deep, unshakable sadness and diminished interest in nearly all activities. The term depression is also used to describe the temporary sadness, loneliness, or blues that everyone feels from time to time. Severe depression, can dramatically impair a person’s ability to function. People will often have feelings of despair, hopelessness, and worthlessness, as well as thoughts of committing suicide.
Depression: other common symptoms

- Loss of confidence or self esteem
- Inappropriate and excessive guilt
- Recurrent thoughts of death; Suicidal thoughts or behaviour
- Diminished evidence of ability to think or concentrate, e.g. indecisiveness, difficulty reading or even watching TV
- Change in psychomotor activity
- Sleep disturbance
- Appetite change with corresponding weight change

Depression in the physically ill doubles all cause mortality (largely cardiovascular, not just suicide)
Common Depressive Symptoms

- Loss of interest in life and pessimism about future,
- Lack of enjoyment in normal activities,
- Chronic pain, fatigue, insomnia, weight loss,
- Feelings of guilt and self-blame
- Persistent thoughts of death,
- Complaints of poor concentration, or impaired memory

Often symptoms are incorrectly attributed by family, friends and doctors to old age, early Alzheimer’s disease or physical ill health with the result that depression may go undetected and untreated for a long time.
Barriers to good care

- Pessimism fostered by societal as well as professional ageism
- Undiagnosed and untreated disorders
- Societal beliefs and attitudes to normal ageing, death, euthanasia, mental illness, physical illness
- Funding and governance structures that do not meet the needs of the aged
Promoting good care

- Comprehensive assessment and treatment
- Positive attitudes and advocacy. Addressing bias
- Partnership with older people and carers and empowerment in managing treatment
- Collaboration and liaison with family, geriatric medicine, health services and community groups
- Awareness of impact on carers and wider community and balancing resources and needs
- Vulnerability vs resiliency and the self-perception of older people
- Awareness of religious, cultural and end of life issues