Accoras

Submission to the Productivity Commission inquiry into the economic impacts of mental ill-health

April 2019

About Accoras

Accoras is a not-for-profit non-government organisation operating in South-East Queensland and Northern New South Wales. Accoras delivers multiple programs that provide mental health early intervention for children, young people, adults, families and communities. We are primarily government funded, holding funding contracts with the Commonwealth, the Queensland Government and local PHNs; we also operate two psychology clinics that are staffed with psychologists who deliver care primarily under the MBS 'Better Access to Mental Health Care' initiative.

Accoras specialises in early intervention in the areas of mental health, employment and child protection. It has been our experience that these three domains are highly interdependent, and as a result we have developed a whole-of-organisation way of working that is holistic and grounded in an ecological approach. Our key indicator that support is required is personal distress and/or a deterioration in social or occupational functioning. We do not wait for a diagnosis or for a certain level of severity and aim to offer support as soon as difficulties start to emerge.

About this submission

This submission will not attempt to directly address the questions posed by the Issues Paper released by the Productivity Commission. This submission instead has been written to provide an insight as to what an early intervention service delivery organisation knows about where there are opportunities to improve the productivity of consumers (and potential future consumers), and the effectiveness of the mental health service system.

On prevention

Our experience working with individuals and families has led us to conclude that optimal productivity can be lost very early in life. Poor attachments with parents, early trauma and exposure to unsafe environments impact on the developing brain in a way that has life-long negative consequences[1]. In our work with psychologically and socially disadvantaged children, adolescents, adults, new parents and family groups we have heads and observed some repeating themes from our clients, including:

- Early relationships with parents and caregivers that lack safety, trust and emotional connectedness;
- Adverse childhood experiences such as poverty, exposure to domestic violence, exposure to physical or sexual abuse, and neglect; and
- Parental mental illness or substance abuse resulting in either direct trauma or indirect loss of opportunities for optimal developmental progress (e.g. poor school attendance, lack of friendships, contact with the child protection system).

[1]Lanius, Vermetten & Pain (Eds) (2010). The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic. Cambridge University Press, United Kingdom.

It is the view of Accoras that preventing these early experiences would have an enormous impact on mental health and wellbeing across the Australian community; this view is based not only on our direct involvement with clients, but on world-class research such as the Adverse Childhood Experiences study[2]. It is also the view of Accoras that such prevention would require a similarly enormous effort that spans sectors and jurisdictions, with bi-partisan political support, and realistic time frames and investment.

Accoras has also repeatedly observed that earlier opportunities to undo some of the damage caused by adverse early experiences have been missed. One particularly salient example relates to infants and children who are placed in out-of-home care following child protection concerns within their family of origin. These infants and children have experienced abuse and neglect severe enough to warrant a statutory intervention in their lives, following which they experience a sudden separation from the only attachment figures they have known – a trauma in and of itself, regardless of how poor their experience of being parented was[3]. Infants and children in the child protection system are already developmentally and psychologically disadvantaged, and at well-recognised increased risk for numerous poor life outcomes including mental illness, substance abuse, and criminal behavior leading to incarceration[4]. Despite all these well-known and widely-recognised risk factors for reduced productivity across their lifespan, there is no universal mental health promotion/mental illness prevention intervention delivered to infants and children entering the child protection system – the provision of a physically safe environment is the primary and often only intervention. The enormity of this missed opportunity really cannot be overstated – the ability of infants and young children to rebound from early adversity with the right interventions[5] mean that culturally and developmentally informed attachment-based approaches, such as skills training for foster carers, dyadic therapy for carers and children, or therapeutic day care programs, could have an outsized impact on the mental health and wellbeing of these individuals across their lifespan.

Instead of this, the mental health service system has a large number of programs and services that specifically exclude children in out-of-home care. Infants and children in the foster system frequently do not receive mental health intervention until their behavioral difficulties are severe[6]. This is an area where a new approach could result in outsized increases in productivity, relative to the investment made.

On early intervention

Accoras believes a focus on early intervention is critical – ideally, as soon as psychological, social, emotional or functional difficulties emerge, there are supports ready to repair damage and prevent further deterioration so clients can return to their previous (or superior) levels of functioning. Early intervention means responding with urgency to warning signs and emerging issues – correcting a declining trajectory before it has the chance to go too far. Organisations that deliver early

[2] Felitti, Vincent J; Anda, Robert F; et al. (May 1998). "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study". American Journal of Preventive Medicine. 14 (4): 245–258.
[3] Howard, K., Martin, A., Berlin, L. J., & Brooks-Gunn, J. (2011). Early mother-child separation, parenting, and child well-being in Early Head Start families. Attachment & human development, 13(1), 5–26.
[4] Zlotnick, C., Tam, T. W., & Soman, L. A. (2012). Life course outcomes on mental and physical health: the impact of foster care on adulthood. American journal of public health, 102(3), 534–540.
[5] Lieberman & Van Horn (Eds.) (2011). Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment. The Guilford Press, New York, USA.
[6] Sawyer, Carbone, Searle & Robinson (2007). The mental health and wellbeing of children and adolescents in home-based foster care. The Medical Journal of Australia, 186 (4): 181-184.

intervention mental health services should be as flexible and responsive as possible to best service the intended cohort of clients. For example, early intervention is ideally delivered before an individual disengages from school or work, so after hours appointments and mixed delivery modalities (in person, online, telephone) should be the norm; service models should be designed in a way that minimises waitlists, so that individuals who reach out for assistance receive it as rapidly as possible, moving into and back out of the mental health system quickly and cleanly.

Early intervention is particularly critical for suicide prevention. While the majority of people who die by suicide have a mental illness, in many cases these illnesses are only revealed during a psychological autopsy[7], and only one third of people who die by suicide will have contact with a mental health service prior to their death[8]. Waiting to deliver intervention only after symptoms are severe enough to meet diagnostic criteria for a mental illness is particularly ineffective for groups at elevated risk of suicide (Aboriginal and Torres Strait Islander people - especially young people; unemployed men; men over 65 yrs)[9]. Accoras has experience in developing and delivering responses to elevated suicide risk within particular groups. The Brisbane suburb of Inala has seen a number of suicides among the Aboriginal and Torres Strait Islander population in recent years. Accoras partnered with the Inala Elders in 2013 to develop UHELP, a social and emotional wellbeing approach that involved the whole community and included a group program delivered to young Indigenous people aged 12-25 years. UHELP was independently evaluated by the Australian Institute of Suicide Research and Prevention, and found to be the first program of its type to show a decrease in suicidal thoughts following participation in the group program[10]. The effectiveness of this approach was in part related to:

- Publicly reframing the task of suicide prevention as a whole of community activity, not something that happens at mental health services behind closed doors.
- Recruiting staff who were best able to access the targeted community and had the best chance of successfully engaging with at-risk individuals – in this case, Aboriginal and Torres Strait Islander professionals with their own lived experience of suicide.
- Taking a holistic view of health – developing a group program that attended equally to physical health, social wellbeing, cultural and spiritual wellbeing, and occupational wellbeing, as well as mental health and help-seeking matters.
- Changing the service approach to fit with the clients, rather than expecting clients to adapt to the service system. This included providing practical support to take part (e.g. transport to and from the group program), working outside of the usual clinical setting and holding meetings at natural community congregation points, and using new assessment and intervention approaches that were not part of the suite of outcomes measures our funders required us to use, but were effective and culturally safe for our clients.

We believe there are generalisable lessons in the above points.

[7] Cavanagh, Carson, Sharpe & Lawrie (2003). Psychological autopsy studies of suicide: A systematic review. Psychological Medicine, 33(3), 395-405.
[8] Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. The American journal of psychiatry, 159(6), 909–916.
[9] Australian Bureau of Statistics (2018). 303.0 - Causes of Death, Australia, 2017.
[10] Skerrett, Gibson, Darwin, Lewis, Rallah & De Leo (2018). Closing the Gap in Aboriginal and Torres Strait Islander Youth Suicide: A Social–Emotional Wellbeing Service Innovation Project. Australian Psychologist, 53 (1) 13-22.

On the role of organisations, programs and individual providers in delivering effective services

Accoras has built its whole-of-organisation approach from the perspective of the client, rather than the perspective of the health system or that of providers. A client-centered and client-led approach is critical to achieving meaningful outcomes. We take a recovery-oriented, solution-focused and strengths-based approach, however the way in which these frameworks inform our service delivery is determined by each individual or family we engage with – meeting their needs, preferred ways of working and expectations is our primary aim. This is because we have learnt that the attitudes of professionals delivering a mental health service is critical. No matter how well evidence-based the intervention or how potentially effective it is, if the client does not wish to engage with the person delivering it, then it cannot succeed. Individual providers need to be collaborative, not authoritarian; they need to be kind and take the time to develop a relationship, not just rush to deliver an 'adequate' intervention and leave again; they need to take distress just as seriously as diagnosis, and they need to adapt the intervention they are delivering to best fit with a client's culture, values and life practicalities.

The experience Accoras has had as a mental health service, and working with other private, NGO and government mental health services, is that the attitude described above has to be grounded in the organisation's culture. It is unrealistic to expect an individual provider to deliver individualised, client-led interventions in an organisation that doesn't value and actively support such an approach. Over the past seven years, Accoras has explicitly drawn on a parallel process model of organisational effectiveness. Parallel process is a familiar concept in psychotherapy[11] – it refers to circumstances when the relationship between a clinician and their clinical supervisor starts to develop dynamics that resemble the relationship between the clinician and the client. Similar to a rock thrown into a still pool, the ripples move out from the center relationship and impact on surrounding relationships. It can be very useful in understanding client issues, and critically it goes both ways – meaning it can be harnessed to improve client outcomes.

Parallel process occurs beyond personal relationships and can effect entire systems. An early analysis of the topic described parallel process as when "two or more systems – whether these consist of individuals, groups, or organisations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviors, which are defined as parallel processes"[12]. Most literature in this area focuses on how parallel process can be destructive – treatment systems reflecting the trauma and chaos of client experiences[13]. It has been the Accoras experience that parallel process can be harnessed for the benefit of clients. Where organisational leaders mindfully provide a psychologically safe and containing workplace, where team leaders provide their staff with guidance, kindness and supportive management, where all information and practical resources required to plan and deliver effective interventions are provided as part of employment, then clinicians are able to provide the best possible support, containment and psychological safety to their clients. This is how good intervention approaches can deliver great results.

[11] Stephanie H. Raichelson PhD, William G. Herron PhD, Louis H. Primavera PhD & Sonja M. Ramirez (1997) Incidence and Effects of Parallel Process in Psychotherapy Supervision, The Clinical Supervisor, 15:2, 37-48.
[12] Smith, K.K., V.M. Simmons, and T.B. Thames, "Fix the Women": An intervention into an organizational conflict based on parallel process thinking. The Journal of Applied Behavioral Science, 1989. 25(1): p. 11-29.
[13] Bloom, Sandra. (2010). Trauma-organized Systems and Parallel Process. Managing Trauma in the Workplace: Supporting Workers and Organizations, Chapter: 9, Publisher: Routledge, Editors: N. Tehrani, pp.139-153.

It is the Accoras view that if mental health organisations were supported to mindfully harness parallel process as part of their human resources and service delivery approach, they would see greater improvements in clients without having to increase their use of funding or other resources.

Conclusion and recommendations

Within vulnerable groups optimal productivity is frequently lost very early in life. There are opportunities available to the current service system to repair the damage done and prevent any further damage, however these opportunities are by and large missed. Across the lifespan, once psychological and functional difficulties become apparent, targeted and individualised early intervention is the best option for minimising the impact on future and current productivity; this is particularly critical for suicide prevention. For clients to be able to use the interventions offered to them, they need to be delivered in a way that is flexible, tailored, respectful and kind.

Accoras suggests the following actions to improve the productivity of people with, and at risk of, mental ill-health:

- Develop and fund a model of service specifically designed to break the cycle of intergenerational poverty, domestic violence, child abuse and neglect, mental illness and substance abuse. Currently there are many services funded to address these factors separately; what is needed is something that addresses these factors holistically and contemporaneously, helping parents to protect new generations of family members from the traumas past generations faced.
- Make developmentally-informed, culturally sensitive and attachment-based mental health promotion intervention a universal expectation for infants and young children in the foster care system.
- Consider structural impediments to achieving a stronger focus on resourcing early intervention. These include a community-wide lack of knowledge of early warning signs, and a lack of awareness within the mental health sector of how possible it is to prevent the emergence of mental illness if symptoms are addressed early enough. There is a 'pull to severity' in mental health, where funding intended for early intervention often ends up being used to assist those with more severe and complex needs. Funding services that specialise in early intervention is a way to prevent this.
- Re-design mental health services so that they are as accessible and friendly as is possible. Mental health services and systems should be supported to mindfully harness parallel process and other approaches that will encourage them to be client-focused, client-led, flexible, tailored, respectful and kind.

Contact details

If the Commission would like further information on this submission, we would welcome the discussion. Contact regarding this submission should be directed to Suzie Lewis, Clinical Governance Manager

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End of submission