Transcript
Listen in: **Eavesdrop on a 'real' case consultation**

The following is a transcript of the "Listen in" activity conducted by practitioners from the Centenary of Anzac Centre's Practitioner Support Service as part of the Mental Health Professionals' Network's Working Better Together Conference 2019 at 3 pm Tuesday 28 May, 2019

John	**Welcome to the MHPN Working Better Together, Online Conference. I'm John Cooper, Consultant Psychiatrist of the Centenary of Anzac Centre and the Chair of today's discussion.** The Centenary of Anzac Centre provides free advice, consultation and support to practitioners nationally who work with veterans with mental health problems. And the case that we are about to discuss exemplifies the fact that this service is also available to folk who work to support veterans even if they are not clinicians. Specifically, our practitioner support service provides case consultation and access to a team of multidisciplinary experts; for advice specific to your inquiry. We have access to psychiatrists, psychologists, general practitioners and social worker family therapists. All very experienced in the complexities and challenges of veteran mental health. Today you will hear these experts as they discuss a current case consultation live, and work though the best treatment options, evidence-based research and practice, and how to integrate this for a better clinical outcome. The case that you will hear about is fictitious and a composite of typical cases that have come to the practitioner support service. When cases come to us, they are de-identified, and every effort is made to protect privacy and ensure confidentiality. Let's get started. Participating in today's session is **Jane Pool** a social worker and family therapist from Adelaide. **Richard Bonwick** a psychiatrist and **Geoff Thompson** a psychiatrist, both from Melbourne, **Phil Parker** a consultant GP from Brisbane and **Kristi Heffernan** clinical psychologist from Sydney. For those on our call you would have had a chance to read over the case notes. But let's start with this particular case. Now we have a worker, Jim, who calls in from an ex-service organisation, Anzac & Friends, which provides social support, welfare assistance and wellbeing programs to veterans. He has some training in community welfare and a lot of experience in working with veterans. So, at this very early stage of the details of this referral**, I'm wondering what the team thinks about the difference in taking calls from non-clinical folk who are working with veterans compared to the clinical referrals that we get. Geoff, what do you think?**
Geoff	I'll jump in, Geoff here from Melbourne. I think one of the things that's really important for us as a group, to be mindful of, is that we are dealing with people who are not clinicians. Some of them may not have any sort of clinical background and it's very important because often these workers are doing really important and critical work and certainly help facilitate engagement and access to appropriate support and treatment for our veterans. But it's really important that we support them if they are being exposed to challenging material and also sometimes the veteran's might have unrealistic expectations of what they can actually do, as opposed to seeking treatment from the appropriate people, so supporting the workers and supporting them in setting clear boundaries, while still providing important help, I think is one of the important aspects of it.
John	Yes, I agree completely Geoff. Let's move on, so Jim is working with a 39-year-old female. She was an aircraft technician in the RAAF, one of few females in her trade. She was in service for 10 years and was a Corporal at discharge. She was referred to Jim's social support groups which included some regular physical activities, such as park walks, yoga and bike rides, and social BBQ's every few months. She got referred because she spoke to an advocate about her back condition and the difficulties getting it recognised by DVA. And told him that she didn't have any close family that she lived with and didn't really want to be involved with any ex-service stuff.

	The client has a history of depression and suicidal ideation following a motor vehicle accident. She was hospitalised briefly, to manage this, and subsequently referred to a psychiatrist for ongoing management. Although Jim's not sure how engaged she is with the psychiatrist. So let's pause there, and **I'm wondering what the team thinks are the likely themes or concerns that are likely to arise for Jim in this particular case?**
Kristi	Kristi from Sydney here, clinical psychologist. I think a couple of the issues thus far are, you are being referred to an ESO to provide social support and assistance, sounds like a really good referral when somebody isn't actually engaged in regular social support, so I can understand why this particular lady had been referred to Jim's organisation, to actually get that social support. One of my issues around that is though she doesn't seem to be a very willing participate at this stage. Regardless she did attend so she's made some sort of, she's got some motivation to go but that's just something to flag at this stage in terms of her actual motivation to attend. And I guess one of the other issues for me, with my clinical psych hat on is just noting that motor vehicle accidents can be potentially traumatic events and so that might be something that we are dealing with here that there might be some sort of trauma informed care that we might need to think about at this stage. They are just my initial thoughts.
John	**Any red flags for you Phil in terms of somebody with a chronic back condition?**
Phil	Yeah of course, she's got underlying medical conditions, they are sort of going to have a contributing effect upon her general emotional wellbeing and potentially her mental health. I think it's good that she's engaged with Jim and what she's provided is a fair bit of information which sort of surprises me for someone who is reluctant to engage, and reveal elements of her past. So that's really good. He's obviously made a, had a big effect upon her and he's quite supportive. It's important that we therefore use that to leverage a little bit more clinical support, slowly, and carefully, so we don't lose her. We don't want to burden Jim with clinical expectations that are far too demanding for him. So we need to use his position to try and engage a general practitioner, potentially at the start, and someone that he might know who can give her an excellent level of support and encourage her to engage with,
Jane	Jane here, social worker, yeah I think some information around the motor vehicle accident would be really important. I'd also be interested in knowing, it says that she doesn't have any close family, that she lived with, so I guess I'm wondering whether that's relationship closeness or proximity close. So some more information in being mindful to build a support network for her, around maybe potential family and or friends. And I guess the other thing that I would be mindful of with Jim is that, sometimes people that do this really good work in our ex-service organisations have their own trauma history as well.
John	**Excellent point Jane, thanks. So let me give you a bit more information that we've got from Jim.** He reports that his client can be difficult to manage. She often gets very angry with him about DVA not recognising her claim. And that even though he tells her that he has nothing to do with DVA, this makes no difference. Despite this she is frequently calling him seeing support. Last week she came into the office in a distressed state, asking to speak to Jim. She told him that she had been speaking with another female vet who she met at a recent BBQ, who told her about being raped whilst she was in the Army. Jim's client broke down in tears and said she cannot stop thinking about her friend's story and has been having nightmares since she heard it. She then disclosed to Jim that she also was raped whilst in the RAAF but has never told anybody about it. She tells Jim that she does not want anyone else to know about it and that he is not to pass it onto her GP or psychiatrist. Jim's not sure what to do. So, **what's your advice expert panel?**
Geoff	Geoff here. Ahm, this is a very difficult, and no doubt uncomfortable position for Jim to find himself in, but it probably also comes about because of the success Jim has actually had in building a connection with the veteran, the fact that she's been attending, she's been revealing information, she came to him at a time of distress. So, in spite of her protests about being angry with him, which is really her anger with DVA, she's very much voting with her feet by her attendance and reaching out to him at times. So, clearly Jim is playing a really important role at that point. But probably partly as a result of that, he now has received from her some information which puts him in a difficult position. And it's always difficult when you are told something and then very promptly said "but you're not allowed to tell anyone!" I'd be sort of, I think it's important that we help support Jim with the impact it might be having on him, but also give him some sort of pretty clear guidelines as to what the boundaries should be. And that is that he doesn't actually have to take on the responsibility for this and that, to as we were saying earlier, the importance of the clear boundaries, that his

	role is to provide support and to perhaps reassure her that to be distressed at this time is understandable. But be encouraging her to take that information to the people who can help her with it, such as her treating team.
Phil	Phil here. I agree absolutely, Geoff, I think he needs to continually remind her that he is there to support her and that the best outcomes that can be achieved for her care is if she engages with people who are going to help her. And to do that it might be worthwhile obviously figuring out whether she has a GP that she sees, we are not sure about that, firstly. And secondly, whether she has received DVA support in terms of mental health care, in the past. We don't really know whether that is there, we don't know if she has a white card, so it might be worthwhile him trying to discuss options for care for her.
Jane	Jane here, yeah I was going to say what Phil was saying as well. And I guess maybe working with Jim to facilitate if she doesn't have a regular GP, but also maybe a referral to Open Arms for some counselling as well. And I guess just trying to work with Jim to help spread the load for him.
Kristi	Kristi here from Sydney. I would probably, I agree with the comments that have been made thus far, it is really, probably very uncomfortable for Jim to have this conversation with her and the sense of responsibility would be apparent, but agree that reinforced to him, one of the things that I would be saying to Jim, I think we need to feedback, is that he does need to be responsible for her safety or her care that a clinical team kind of is necessary, but also sort of giving him just some information about, that sexual assault, rapes, can be really traumatic and it really does, can, destabilise people, that distress that she's experiencing is quite normal, if she's been triggered and that safety and trust is really important in relationships, and that her ability to disclose to Jim means that he's kind of developed that nice safe and trusting relationship with her and that's really important. But encourage her to then actually seek help by professionals who can help her with that and the difficult then of telling somebody for the very first time, that she never told anybody about the sexual assault in the past, that Jim is the first person, kind of explain to Jim that that can be a first hurdle and that it probably would be easier for her to seek help from here. Because she's already kind of disclosed that but it's also important to get her into help because of the highly distressed nature that she's in.
Phil	Phil here, Kristi I agree, and I think her asking for help, or willing to disclose to Jim about the rape, suggests that she's now a bit more open to seeking help, or seeking support, for her background, yeah.
Kristi	Yeah and it might be, particularly the trigger seems to be having contact with the other female veteran in the group, but in the background of a recent motor vehicle accident as well, her sense of safety and trust in the world has already been shaken and destabilised by that as well, so there's a combination of those factors building up now for her to really seek support.
Jane	Jane here, yeah agree with all of what's already been said. We just need to be also mindful that she did have a period of being quite suicidal after the car accident, and we can potentially put two and two together around stress levels and monitoring her risk at this point in time as well, and that's a really big ask for Jim.
	Yeah.
Richard	Richard here, psychiatrist, it seems like the key role for Jim is to facilitate the right sort of support and assistance for her, professional support and assistance for her. And one of our major roles I guess is to provide information to Jim about what sort of services are actually available so that he can assist with that facilitation. He may or may not be aware of mental health service, he may or may not be aware even of the VBCS or Open Arms, so I think giving him some clear direction about that is very much a key to this.
Kristi	I agree Richard, it's Kristi again from Sydney, but also giving him the list of emergency contact details that if it does escalate and if he does need to call 000 and down to that level of detail I think we can provide that level of support to Jim.
Jane	Yeah and maybe we can find out from Jim, what kind of support he's able to get through Anzac and Friends, and whether there's a process already in place for supporting Jim with the work that he's doing as well, and capitalising on that
John	**It's John here, would it be fair to say that in relation to these thoughts about how Jim is supported, in his organisation, is this the sort of situation where, what's called trauma-informed care would be relevant? Either for Jim as an individual or for his organisation as a whole in terms of further training or assistance in that direction?**
Kristi	Kristi from Sydney here, yeah absolutely John, I think more education around trauma-informed care principles are really important. I've mentioned them thus far just at increasing people's sense of safety, trust, the level of control and empowerment to make decisions, that they are really key ingredients with regard to trauma-

	informed care, because once somebody has been through a trauma, they are the things that tend to destabilise people and to regain a sense of emotional control, it's really important to try and facilitate, and Jim is the perfect example of the types of people that we would usually educate people on trauma-informed care principles. They are really the first responders with regards to mental health, we as clinicians, we get referred from the first responders, so it's really important that we re-educate people on the ground so to speak, in that first responder role, around what they can do to kind stabilise the situation. As well as give them the emergency contact details and things when risk is present. And also, the referring treating kind of teams and things that people can then access so I think that's really important. And as part of the PSS, we also do provide educational seminars to organisations like Jim's, with regards to just increasing mental health awareness, and also how they can maintain their own self-care, educational seminars on what good family support systems look like for veterans, and things like that. So there's a number of educational seminars that we can, that we do provide to these organisations, for this purpose, to try and increase their knowledge and think about some skills they might want to develop in this area.
John	Thanks Kristi. **Let me be the devil's advocate here, and Jim comes back to us and says that he's said and done all of those things to his client, but she's still adamant that she's not going to seek professional clinical support. What do we advise Jim under that circumstance? Phil?**
Phil	Yeah, this is Phil, it is certainly a difficult one, it's put him in a position where he will feel quite isolated in terms of his responsibilities of caring for her. We probably need to, we can't expect him to assess her risk, although he might have some ideas about whether he thinks she's a danger. I think we need to find out what her agenda is, she's obviously starting to open up and she's willing to engage with him and connect with him and reveal some of the really sensitive deep issues from her background, but we need to, probably, get him to continue to ask for her willingness to engage with people who can help her, but it's so dependent on what she wants to get out of that. Just wondering what the thoughts were of everyone else on this?
Jane	Jane here, yeah, I agree, I guess I would go with what's already in place. We know that she has a psychiatrist for ongoing management, but we are not really quite sure how engaged with the psychiatrist she is. So finding out her level of engagement might be of use, and again, finding out whether there's any other supports, non-clinical support in her life, in terms of family and or friends or if she's working, anything that might just broaden the level of support that we can get to this client. And then if there is somebody that's particularly close to her, then they may be able to facilitate a referral to clinical involvement.
Kristi	Kristi here from Sydney. I agree Jane, I think that trying to establish what other social support she's got is really important so that that's really important in terms of her care, but also so that Jim isn't necessarily dealing with this on his own. He also has the support of his own group, so even though it hasn't necessarily been motivated to attend, she has attended, and while she's discussed with another female veteran, her own experience, was triggered her own emotional reaction, but there might be other people within the group that this can form a supportive environment for her and also for Jim as well, so he's not necessarily managing this on his own, and with time, hopefully, and still encouraging her to seek help and going back to her GP, that support can facilitate her help seeking from a clinical support.
Jane	Jane again and I guess that the other thought that I have is, it would be really important for the ducks to be in a row, because there might be just a window of opportunity where this person goes, yes I will, you know, I will seek the clinical support, so having that information, and trying to facilitate that as quickly and as seamlessly as possible would potentially help that initial engagement process.
Geoff	Geoff here, psychiatrist, ahm, look I think we've seen with his client that sometimes what she says and what she does, they don't align, so she has been voting with her feet, she has been attending even though she is probably verbalising often that she prefers to be isolated, and not connected, so reassuring Jim that continuing to invite her to be part of their activities, and to attend, and to move amongst other ex-servicemen, I think is playing an important role and to not underestimate the value of that for his client, in an ongoing process. I think also we can reassure Jim by informing him that people who have been sexually assaulted, it's really important for them, that they don't feel forced or coerced or pressured to explore things until they are actually ready, and to reassure him that that sometimes takes quite some time. It could be months, it could be years on some occasions, so providing that the limit of what he can actually do is continue to encourage her to be engaged with the people that can help her, encourage her to look after herself and connect with people, and connect with their group and reminding Jim of the fact that the things he's doing are actually really valuable. And that there is a limit to how much he can do in terms of the decisions that she might make for herself in terms of her

	care.
Richard	Richard here, psychiatrist again, it sounds like patience and polite persistence is the key. Often we want to fix things, but sometimes you just have to be patient and just persist with what is the right plan and I think that's really what you've articulated Geoff.
Phil	Phil here, I agree, I think we, our ultimate goal is to build her clinical support team, the right team for her, one that she trusts, and will engage with, to get the best outcomes, but we need to maintain support for Jim throughout this process and yes it may take time, and we may need to give him options if he believes that she, her level of risk has increased as well.
John	Thanks Phil. John here. **And if I can summarise what we've discussed today.** Jim, working in an ex-service organisation, supporting other veterans, a very difficult scenario, of a distressed veteran with trauma in her background and other complexities around her medical and social circumstances. We want to provide Jim with information and education. We want to reassure and support him in the excellent work that he's doing. Part of that education is going to be around his self-care and how to maintain good healthy boundaries, and this is going to lead us into work that we would call trauma-informed practice. And that might be relevant for him as an individual, but it might also be relevant for his organisation. And in his organisation if it's to support the work that they do. **So thank you all for your excellent contribution today. Thank you to those listening in today.** **When you contact the Centenary of Anzac Centre for practitioner support service for advice, we take your veteran mental health question or problem. We consult with our experts, just like we've done today. And we provide specific advice back to you. This is a free service. You can access this service through our website, at www.anzaccentre.org.au or you can call us on 1800 VET 777. Thank you very much.**

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The Centenary of Anzac Centre is an initiative of Phoenix Australia, supported by the Department of Veterans' Affairs.

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