## Improving your practice: Working across sectors

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Dr Ruth Vine (00:00:06):

To everyone who's watching tonight and of course a welcome to those who might later listen to the recording. My name's Ruth Vine and this is the sort of inaugural multidisciplinary mental health practitioners network webinar and I'm delighted to be part of it. I'll get round to introductions shortly, but the first thing I wanted to do of course, was to acknowledge the traditional custodians of the lands on which we meet and on which our webinar presenters and participants are located. For me, it's the Woiwurrung people of the Kulin Nation. I pay my respect to elders past and present and acknowledge the memories, traditions, culture, and hopes of Aboriginal and Torres Strait Islander peoples. So now as I said, my name's Ruth Vine. Very briefly. I was trained as a psychiatrist but have also been in administrative and bureaucratic roles, and I'm going to moderate this evening's webinar, but I'm joined by a terrific panel of people from different professional backgrounds and indeed different jurisdictions. And I'm just going to introduce them by turn. So I'm going to start with Michael if that's okay. Michael Tam. Michael is a general practitioner in primary and integrated care unit in Southwestern Sydney local health district. Michael's also a great teacher and much better at webinars than I think I am, but welcome Michael. Thank you for joining us.

Dr Michael Tam (00:01:34):

No worries.

Dr Ruth Vine (00:01:35):

And next, Dr. Paul Fung who is a consultant, liaison psychiatrist, but also the clinical director of mental health and wellbeing services at uniting and that Uniting covers services across New South Wales and the ACT. And I first met Paul, I think this is correct, Paul, when Paul had completed his Churchill Fellowship, which was a really interesting one and very relevant for this evening. And Paul very generously provided me with a copy of his report and we got to catch up. So welcome Paul. Thanks very much.

Dr Paul Fung (00:02:11):

Thanks Ruth. I must say that I'm not a consultation liaison psychiatrist, but I'm a general psychiatrist and I will have my general psychiatrist hat on for a range of different scenarios and I thank you.

Dr Ruth Vine (00:02:25):

That's terrific. I can only say so I'll have to complain to MHPN for giving me false information, but that can be for later. And the next person I'd like to introduce is Tracey Hocking. Tracey is a community-based social worker, but she's also the general manager of a large state-based non-government organisation that delivers a whole range of residential and subacute services. And Tracey, I think you're resident in Queensland at the moment, is that correct?

Tracey Hocking (00:02:55):

I'm in Queensland, that's right. But I run services across multiple states. So yeah, very happy to be here.

Dr Ruth Vine (00:03:01):

Yeah, that's great. And last but absolutely not least, a person who I actually worked with for a number of years, Margaret Foulds, who's a very psychologist in private practise, but for many years was also a psychologist working across the public sector as well as the private sector and has also worked, I think Margaret, it's fair to say in terms of organisational consultancies. So Margaret, both from a psychotherapeutic point of view delivering psychological treatments, but also working as I said in those sort of complex acute and community-based mental health services. Margaret, lovely to see you. So what we're going to do, having introduced everyone, what we're going to do is each of these terrific people have provided me with a sort of vignette that I'm going to sort of tackle them and others with that hopefully will shine a light on various aspects of multidisciplinary care, a bit of the how to or maybe the how not to of cross-sectoral multidisciplinary care.

(00:04:14):

And of course this fits well with MHPN's aim of promoting and showcasing the value of multidisciplinary care and indeed of engaging professionals across the spectrum. So we will talk about the vignettes, I'm the only person other than the author who's seen them and we'll sort of hopefully stretch them out a little bit, not make them wild and weird. I think we'll try and stay very reality based, but as many of you would know, reality can be pretty challenging. So I'm allowed to ask what I like, others are allowed to ask each other what they like and we'll see where we get to. But it is a hypothetical, we'll just see where we go and see where we get to and see where the complexities arise. I and please, the other thing I'll ask the panellists to do, because we do come from different jurisdictions, if there are particular glitches or great innovations that occur in your jurisdiction, then feel free to let us know.

(00:05:26):

And of course before we launch into it, because this is an MHPN activity, you the viewers, the listeners can access CPD points for this. So if you want to access the learning outcomes for that purpose, I think you'll find them in the supporting resources tab. And please, if you are experiencing technical difficulties, just click on the technical support tab and you'll find a tip sheet and both of those tabs are located or should be located in the top right hand corner of your screen. And if you're still experiencing any difficulties, please post a request in the checkbox. So without more ado, I'm going to kick us off, but actually before I get to the vignette, Paul, I can't resist just having you scratch your head a bit about what you learned on your Churchill Fellowship that is relevant for multidisciplinary care. And indeed, when I say multidisciplinary care or multidisciplinary care planning, what do you think? I mean, so you want to just give us a few thoughts from your travels and your reading in that area?

Dr Paul Fung (00:06:41):

Yeah, thanks. Multidisciplinary team care obviously refers to different professionals from different disciplines that work together in a team. And I think that's the key is actually what that teamwork looks like. And that teamwork's going to look different whether you are in an inpatient setting, whether you're in a community mental health team or whether you're potentially in a general practise. And what I did my work on was looking at some of these different ways of doing team within that general practise setting and how that better connects also to community mental health teams as well. And so members of multidisciplinary team could include allied health staff, nursing staff, medical staff, and also lived experience peer worker staff too. Interestingly, when I went to visit the US, there were some other additional roles including health coaches. And

when I went to visit the UK social prescribing link workers and I got to see how those roles got to work together within a primary care setting as well in New Zealand where they had all three roles, a mental health clinician, a health coach, and a social prescribing link worker within a primary care setting working collaboratively together in New Zealand.

Dr Ruth Vine (00:08:18):

Thanks for that, Paul. And I think one of the things that you didn't mention I don't think, but I think is really important is if we're going to have multidisciplinary care, how is it going to be paid for? And some of the challenges that arise because we might want to do multidisciplinary care, but in fact the system doesn't actually support it. But let me jump to our first vignette and Tracey, I couldn't really go past yours so people you're not going to need to take notes, but in effect, Tracey raised the issue of a male in his sixties who had a long history of difficulties in social. He was in child protection as a kid, he failed school early, he had multiple, multiple contacts with mental health services.

(00:09:10):

He'd also had engagement with the forensic system, but his current situation was that he was in supportive accommodation funded through NDIS with a lot of supports in place. He also had a range of physical disabilities including, I'm just going to read some of them because I think they're important. Type two diabetes seizures, perhaps some cognitive decline. So awful lot was going on and right now what the services we're trying to do was transition him not for the first time. I think Tracey, for the 18th time transition, this man from the very highly supported accommodation to independent living. Now Tracey, can you just tell me how many professionals are involved in this person's care?

Tracey Hocking (00:10:07):

Well, I think as you've mentioned, there's a whole heap of systems around this person that generally will have at least one or two representatives in this person's care. So we've got the setting where he is transitioning out of which is a forensic mental health setting. And so there's a whole heap of his treating team is allied health supports in that setting. There is also then all of his NDIS supports, so he's housing provider in the community, allied health funded by NDIS. He's also subject to guardianship and public trust, say some other decision makers involved in this person's life as well. And so it is quite common in these situations for us to go into care team meetings or stakeholder meetings with upwards of 20 people all hopefully working towards the same goal. But as you mentioned, Ruth, we're all being funded by different systems and sometimes that slightly changes the way we can work together and we can interact with each other because of working within the scope of what our funding may or may not allow. Certainly as a social worker you can get pulled in different directions depending on which context you are in. If you're working in that mental health system, you've got that particular scope. If you're a social worker working as a specialist, support coordinator funded by NDIS, you bring all that social work skill and knowledge to that space. But again, of a very limited scope. So there are a lot of people and lots of different lenses that are coming through.

Dr Ruth Vine (00:11:59):

Does there need to be a leader who is the person or body or organisation or whatever it might be that ultimately has responsibility?

Tracey Hocking (00:12:12):

Well, that's often the biggest challenge because there's a tension often across that space who has the responsibility when working with people in that forensic setting and still in that quite active kind of treatment phase. Many people would say that that's where their treating team and the psychiatrist are on that clinical governance. But there's often tensions around who's leading who. There's often tensions around people wanting to have people discharged from hospital, but the support's not being in place in the community. And yeah, there's that tension that we have to navigate working across these systems because often there can be a bit of the term argie barge comes to mind, but I don't really don't think you're allowed to say be nice as possible is the leader in that space whose agenda we are following. And I think one of the things that then we have to be careful of is in our professions and as multidisciplinary teams is the person's lost in all of that.

Dr Ruth Vine (00:13:26):

Well, there's two things that bring to mind, but just before we come back to the person lost, Paul, you work in a non-government organisation as well and you'd be very familiar with situations like this. What is the role of the psychiatrist in this sort of complex persons support care, even interpretation I guess, to other members of the team?

Dr Paul Fung (00:13:56):

And as you mentioned, Tracey, the treating team often feel as though they're in charge and it depends I guess on the setting and also the legal status under which the person sits. But I would say that when it comes to transitions of housing arrangements for people with severe and complex mental health presentations, that the psychiatrist is quite involved when it comes to decisions, not just around medication, but also whether this person is suitable to be in a particular place or not. That kind of measuring up the pros and cons. I think the psychiatrist often will take some leadership around that and of course taking into account the information from the multidisciplinary team around whether there are additional risks that currently the psychiatrist might not be aware of or the team might not be aware of as well. And so I think holding all that information together I think is a big part of the psychiatrist role.

Dr Ruth Vine (00:15:24):

Paul, do you think, I mean I did a bit of this work myself, but do you think part of the psychiatrist role in a sense is also holding the risk, holding the risk for making sure that others know in a sense that you've got their back?

Dr Paul Fung (00:15:41):

Yeah, absolutely. And I think when teams across different sectors are working well together, you've got that kind of free and easy movement in and out of being involved. And so the psychiatrist is still going to be present even though they might be in a different care setting. And knowing that the psychiatrist is able to be called upon because of their good knowledge of the risks of the patient, ongoingly I think is a really helpful thing for teams to be able to do for another.

Dr Ruth Vine (00:16:24):

Yeah. Hey Margaret, one of the things that is not uncommon with this kind of person is that alongside that long diagnostic list that might have a psychotic illness and it's got some drug and alcohol abuse, invariably somewhere in there will be personality disorder probably of the antisocial type if not of the borderline type. And in fact, these people can be quite hard to get along with because they can be erratic, they can be

frightening. What do you think the role of the psychologist is in helping the team to work with this person and helping the team if you like to stay a little bit cohesive rather than the argy barge that Tracey just mentioned?

Margaret Foulds (00:17:09):

Hi, yes, thanks Ruth. I would agree that they are features that we often find in this situation because of people's very difficult backgrounds, they develop all sorts of problematic coping skills and are affected often quite badly. I think one of the things that I would hope is that the team, the psychologist can help the team work together in a similar way to provide good containment for someone like this. Because one of the worst things for a person in this situation is to have different people having different expectations, responding to different things differently, risk requests, things like that. That's very uncontained. So hoping to get people on the same page and helping people to understand how this man thinks about things, what might be motivating him, what his hopes are, how to encourage him, how to not make things worse or get him up unnecessarily upset.

(00:18:42):

And often that requires getting the people who know him best to be able to communicate that, to relate stories about what's happened so that we can drill down to some of the principles that are really important for a man like this and then develop some principles that the team can work on. And that's often a really big challenge because people like me might see someone once a week for an hour. There are other people who are working day to day with someone like this and the pressures and demands on someone like that are very different. And so the team has to really support the people at the front line and help them to contain someone like this.

Dr Ruth Vine (00:19:36):

And that's a terribly important point, isn't it? That recognition that some people in the multidisciplinary care setting are likely to be with that person for hours of the day. They're likely to be with that person overnight, whereas many of the others might just as you say, come in, see them for an hour a week or even less. And your other point there around the principles, Michael, I think this is something that I am thinking, but you can tell me general practitioners struggle with because here's a person who you probably could do a lot with, do a lot for in terms of their physical health and wellbeing, but they might not be on the same page. They might not want to have the sort of diet or exercise or self-care that is going to maximise their physical health. How does the GP manage that tricky tension between personal choice in a patient like this, the expectations of the team and what you sort of know is good practise?

Dr Michael Tam (00:20:40):

Yeah, good questions and it was really interesting hearing discussions so far. Actually Gladica last I think, and I think Tracey, you mentioned that when we were sort of talking about who holds some responsibility that the patient can sometimes get lost amongst it when there's so many different team members. And I suppose I'm a little bit lucky now in that I used to work in private general practise. I had a few consumers who would be similar to this individual in the scenario. I've got some consumers now I work within the state health service within a mental health service, but providing a physical health service and ideally from a principal perspective, you want everybody within the multidisciplinary team to be accountable to the patient, to the person themselves. But the challenge is when you have so many issues and challenges and so many people, you start splitting the person into little issues.

(00:21:47):

So there's a psychiatry bit, there's a housing bit, there's a behavioural management bit, and from a general practise perspective, we often don't think of it in that way. We sort of think of it in a much more lumpy way, so it's not a separate physical health mental health issue. They're all linked together. If we think in that way for this particular person, what are they most likely going to die from? It's probably going to be cardiovascular disease given their age and they've got diabetes. Presumably some of the management of that will be challenging. And when I see some of my consumers who might be relatively uninterested, if you just sat them down to have a discussion about doing more exercise, eating well, it may not be exactly the sort of thing they want to talk about, but at the same time, if you ask people what they actually do want, most people want to be well, they want to be fit and healthy and they'll have some psychological conception of what that means for them.

(00:22:56):

And if you work on that, very often the crosscutting sort of things come out and so that is eating healthily though you might not use those sort of words. It will be about doing more physical activity though you may not be prescribing a physical activity schedule per se. It may be reducing substance use, stopping smoking and focusing I think sort of from a general practise perspective to focusing on what it is the person wants to be different about their life from the dimension of health, what it means for them to be better. That often becomes the hook that leads you into somewhere. When I speak to a lot of my consumers about for eating more sure, they've had sort of the lectures before from various people about cutting out calories, eating your vegetables, all that sort of thing. And eating and diet is complex, it's pleasurable, people like it. And so sometimes it's focusing on making pragmatic small changes that a person can actually make and someone who drinks a lot of Coca-Cola for instance, it might water's best, but sometimes there might be a substitute that for that person will be better than whatever it is that they're doing and it might be quite acceptable to them. And those sort of wins can then become the narrative

Dr Ruth Vine (00:24:28):

A bit of a hook

Dr Michael Tam (00:24:29):

On. That's right. That allows you to develop some credibility I suppose with that specific individual about further changes.

Dr Ruth Vine (00:24:37):

Can I just ask, and anyone can answer me in this sort of scenario, how important is it that those involved in the treatment care support of this person know each other and even more respect and like each other?

Tracey Hocking (00:24:56):

I think it's very important. I think we know relationships go a long way and I think building those great relationships across multidisciplinary teams goes a long way. And to have that mutual respect for each other, to be able to have robust conversations, respect each other's discipline and what we're all bringing is of equal value is really important. In scenarios like this that includes the voice of the person as well, that is absolutely equal if not more value and where possible. But it's tricky when people don't have that voice or when they've

had their decision making impacted and we're trying to support them with supportive decision making where possible so they still can have that voice. But I loved what you said Paul earlier, it's about having each other's back. It's about feeling that we can work together and as a cohesive team and often that can be missed, especially certainly in the community sector, it can be missed and feeling part of a team where everyone's supportive of each other would be great to be able to achieve.

Dr Ruth Vine (00:26:16):

Oh yes, no, Michael, please chip in. And Margaret, Michael and Margaret,

Dr Michael Tam (00:26:21):

I absolutely agree with that. I notionally work within integrated care, which is why I'm a gp, but work within the state health service and absolutely I think interprofessional relationships in complex care, it is crucial. So teams don't work if the individual members of the team are working in parallel or maybe even in conflict with each other. And where social creatures, it's very difficult to work within a team where you don't really know the other person who's caring for the person or worse, you don't even particularly like it. Or where there may be some certain biases or beliefs about different professions, that often becomes a very unhelpful barrier because the person is meant to be at the centre of integrated care. And the challenge of course is sometimes our health system has structures in place that actually make those relationships, those interactions between care providers actually quite challenging within mental health. When I was a junior doctor, when I was first started general practise, if I needed to contact, for example, the community mental health team, I would just phone somebody. Now generally everything goes through a central intake line. I completely understand why that exists because of the volume and workflows and efficiencies, but that structure has created a layer of abstraction. It's actually very difficult.

Dr Ruth Vine (00:28:08):

The direct phone call, that's what we all like

Dr Michael Tam (00:28:10):

And I can understand why that help exists and notionally it helps with integrated care, but actually it really, it helps with a certain domain, but it's actually taken something away as well. Now we may not necessarily be able to fix those things, but when we think about supporting integrated care or supporting team-based care, we need to think about what are we actually doing in terms of how we're designing models. Ideally we want to have a good model of care and then create the structures that support that. And that might be funding structures, it might be a number of other structures as opposed to necessarily retrofit the idea of team-based care around existing structures, which might actually make it quite difficult.

Dr Ruth Vine (00:28:59):

Yeah, look, let me come back to some aspects of what you've just raised, but Margaret, your thoughts about this one, the relationship issue.

Margaret Foulds (00:29:06):

Well, I think sometimes to facilitate the relationships you need fewer people. I mean, I've sat in some case conferences with upwards of 25 people and it can't work with too many people and I don't know what a critical mess is. Stools need to have three legs to stand up, so that's my minimum, but what you need over and above

that, but often depending on the complexity of the situation, you can get a lot of people involved and often it's too many to really to be functional, to do good work.

Dr Ruth Vine (00:30:00):

Which I guess comes back to that question of who is the core, what is the core group? Who is the key person that sort of key decision maker or key coordinator? I'm not going to stay on this vignette forever promise, but it does raise, oh, Paul, sorry, I think I saw your hand before I,

Dr Paul Fung (00:30:21):

Yes, no, I just wanted to make a quick comment. I think around any complex presentations, the anxiety of a system always goes up and I often think of a team much like a family, and so when there's increased anxiety within a team, there are natural predictable patterns of interaction that can occur. We're talking about triangulation, we're talking about blaming, we're talking about insiders versus outsiders, under-functioning, pursuer, distance of relationships. All these things which occur in families when it's under stress actually also occur in teams. And actually when you've got some good mechanism potentially to kind of assist that out, and we actually have used a family systems supervision approach to have an external person come in and support our teams, that actually reduces a lot of the inefficiency that comes from the RG barge. What wastes time?

Dr Ruth Vine (00:31:31):

Yeah, yeah. Tracey, is that you?

Tracey Hocking (00:31:35):

Yes. Just very quickly to add, I think that just to

Dr Ruth Vine (00:31:39):

Go for it,

Tracey Hocking (00:31:40):

Follow on from that. Certainly a lot of my practise, I focus around the trauma informed practise and it just mirrors what you said there, Paul, around you can see that play out in teams, you can see that lack of psychological safety across multidisciplinary teams. In cases like this, people are wrangling with a high level of risks. They're wrangling with systems that aren't always funded the way we would like to best support the person wrangling with enormous stakeholder groups and all of the things that those bring. And so often you can see that whether we frame it in family systems, we frame it around trauma informed, whichever way we want to look at it. But you absolutely do see it play out. As others have said in our groups and when we're all feeling a bit dysregulated or not feeling great psychologically safe, then we're not doing our best work either.

(00:32:36):

But certainly you see that play out a lot and system kind of creates an adversarial climate. Sometimes you've got health saying must discharge this person. You've got NDIS saying, yeah, I'm not going to fund this person. And then you are in the middle trying to do something with two systems that don't align, which again, we're only people ourselves and I think we have to acknowledge that that often for us cannot not feel particularly

psychologically safe. We're wrangling with things personally as professionals and people as well and we need that support so we can do our best work.

Dr Ruth Vine (00:33:11):

Well, and I think you called this, I think this person you referred to him as Gary, Gary exists, Gary's there and Gary has real needs and Gary has real anxieties. Margaret, I think you were wanting to,

Margaret Foulds (00:33:31):

Just picking up on the Tracey's comment about psychological safety for the workers. I think that's where people being clear on their roles and responsibilities is really protective for workers having worked a lot in terms of critical incident debriefing and that it's people, if they know their role are trained for their role and can stay in their role, then they're much better off when things do go pear shaped, which very often they do. And I think not being clear on their responsibilities, what really can they do? What is reasonable as opposed to what we hope we

Dr Ruth Vine (00:34:29):

Might aspire between the heroic if you like and as you say, being so clear about not in a retreating obstructive way, but still being clear about what is my role, what is my scope, what is my area of expertise, what am I contributing and what am I expecting of others? Yes, there's so much in this one, isn't it? It's so rich. But because one of the other things I was thinking and in fact Paul, you reminded me of this in your first, when you first mentioned New Zealand and the different people working in the primary care settings with this person, we could imagine, we could imagine Michael coming in as a general practitioner needing to be paid through an MBS benefit bulk build or not. We can imagine Margaret, you perhaps providing psychological support or intervention, again, needing to be paid through an MBS benefit or through a private consultancy. We can imagine Tracey's organisation receiving funding through NDIS and perhaps through government and we can imagine the psychiatric service that Paul's brought in being one of the state services. So perhaps Paul's on a salary. Can anyone tell me just how complicated our system makes providing multidisciplinary care? Who wants to kick off on that one? It can be just a yes

Margaret Foulds (00:35:56):

Or a no. Oh, it's shocking. The paperwork's shocking. If you are private, it's dreadful.

Dr Ruth Vine (00:36:05):

And what would you do to make it better Margaret?

Margaret Foulds (00:36:12):

Oh god, how long have we got?

Dr Ruth Vine (00:36:14):

Not long.

Margaret Foulds (00:36:16):

Well, for private people, the billing has to be simpler and getting recognised in the system once you can get set up into something, usually it can go pretty quickly, although you may not get paid very quickly, but it's that how

you get in and get it set up and organisations keep offering you these really terrific here do it all online and it ain't simpler.

Dr Ruth Vine (00:36:50):

I'll just sort of leave that one hanging. But I think successive governments have tried and certainly successive health bureaucrats have tried to think of ways of lessening the conflict that does exist between a salaried service, a case managed sort of if you like a budgeted service like NDIS, you've got so much money or so many hours of support or so what it is and a private practitioner. But we might come back to that. Let me, I feel like I've exposed you all to the vignette that Tracey helped provide. I'm going to do a complete reversal almost and this one will be a shorter discussion I think. But Paul, you raised the question of an elderly man from an ethnic background who didn't perceive that they had any psychological problems but absolutely was concerned about their physical health and who wanted a particular response and in fact the person didn't accept what the GP had advised and didn't come back. I just want to touch a little bit when there's several people involved in this particular case, you wanted a psychiatrist to be involved or you wanted a psychologist to be involved. The GP was sort of involved. The patient just wanted a cardiologist to be involved. What do you do when what the patient wants is not the same as what the practitioner might think was advisable and you're trying to coordinate care around that person? I hope I've managed to synthesise your vignette adequately, Paul,

Dr Paul Fung (00:38:40):

And I'd actually like to handle this one really quick to Michael because actually I think as when I wrote the vignette, I really was thinking of Michael and this 70-year-old Chinese man in your office, Michael, and some of the challenges of not wanting to accept that they have a mental health issue, but of course a focus on their physical symptoms.

Dr Ruth Vine (00:39:18):

And Michael particularly, this is a GPS conundrum, but particularly how would you involve other, because talking about multidisciplinary care, how would you involve other practitioners when the patient actually doesn't want to borrow it?

Dr Michael Tam (00:39:31):

Yeah, look, it's gently is what I would probably say. Sometimes it's useful to take a step back a little bit because the patient showed up in the primary care setting, you actually paying for something so you want something. So presumably there's an issue that you want addressing. If you didn't think you had any problems and you wouldn't go to see a doctor, you wouldn't go to see a gp. So this person is concerned about something and it sounds like notionally something around their heart or they have a preformed conclusion on what the correct action should be or an expectation of what the action should be. They need to see a non GP specialist of this note about something, but they dunno presumably what's actually wrong. That's why they want to see this other person. So that's where you start with I suppose, and I'm going to take a little bit of a sidestep about this very specific issue thinking about some of the other consumers we have at our practise where for instance, they don't believe they have diabetes but they kind of do or they have a very strong delusional belief that there's something wrong with their bowel and they need to have a procedure but they don't.

(00:41:00):

And then it becomes really, well, what are the functional steps? Sometimes we don't have to agree with the state of reality in words about what the diagnosis is or what you think you might have or what. I think we can

even acknowledge that, well, we might not agree on this, but we can sometimes agree on a concrete plan about what the next steps should be and for that plan to be mutually acceptable even though how we got to that mutual agreeance about what the management is based on very different philosophical worldviews about what's actually happening. So for this person with their concern about their heart, there may need to be something that has to be done. That's what it sounds like in this scenario. It's just that they don't need to see a cardiologist, they need to potentially see some other people. Is that the case?

Dr Ruth Vine (00:42:04):

Well, the person declined to see anybody else, so did go and see a cardiologist and then declined to see the general practitioner anymore. So just I think quite briefly if you can, maybe there are times when you can't involve other practitioners. Maybe there are times when you just have to say, I'm going to have to wait until the person comes

Dr Michael Tam (00:42:23):

Back. And the thing in general practise, well one of the advantages we have is we don't need to solve everything.

Dr Ruth Vine (00:42:29):

No, you don't need to solve

Dr Michael Tam (00:42:31):

The episode of care can occur over a number of consultations, a number of visits, and often that movement through time there will be some agreed things, something

Dr Ruth Vine (00:42:42):

Will change

Dr Michael Tam (00:42:43):

To be done. Presumably they, it'd be very reasonable to do some particular tests which don't revolve referral to anybody at this point in time. And then when the person comes back, it's about trying to come to some general agreeance to the plan. Now for a person who may not want to let's say be referred to see someone for psychological therapy or maybe to an allied health practitioner for some sort of meaningful intervention, a declining of that at a single point in time doesn't have to be a threat to the relationship. It doesn't have to be even the end of the conversation really.

Dr Ruth Vine (00:43:26):

I think that notion that there's a place and a time for you to bring in other people is a really important one. Michael, I did say Margaret I think wanted to chip in, so I'm just going to let know how to say, want to move to another vignette.

Margaret Foulds (00:43:42):

Yeah, I guess I'd note that I've seen quite a few what I call hostage patients over the years and that's where someone's sort of metaphorically tied them up and dragged them in, be it a wife or a gp. But I would say

trusted GP does have a lot of mileage with people is my experience that you can get people who really don't share the same belief about it, but that relationship that sometimes has been built over years and years can often get people through the doors. So I'd never underestimate the value of the relationship, but one thing that can say giving someone to psychologists, usually you can agree on people being stressed and stress is one of those, I'm not sure it's actually on the list of things that are meant to be treated under mental health care plans but not really listening that if to go and talk to someone about being stressed and even if it's about them not getting what they want from other people. And once you can get people talking and you can start some engagement, you can possibly open things up and it might, and then there's the readiness. It is working on that readiness for other. So

Dr Ruth Vine (00:45:23):

I guess what I'd say about that is there is a bit of a combination there of time which Michael's touched on and relationship which you've touched on and language, which is a really critical thing. Okay, I'm going to move again. I hope our listeners are keeping up with us. Margaret, one of the things in your vignette, so I'll just quickly again summarise this. This is a 3-year-old, so a younger person, single unemployed person who is residing with her elderly father who is very frail. This person has a number of issues. She has post-traumatic stress disorder symptoms. She manages some of those symptoms by use of alcohol. She also sometimes abuses substances and at times is intensely distressed or disordered and turns up at the local emergency department to be managed by acute psychiatric services. She's got a psychologist and she engages well with the psychologist in a supportive way rather than in a structured more change oriented psychotherapy.

(00:46:38):

And she's got a psychiatrist and so she's on some antidepressant medication, but she's also in an incredibly fragile situation because her dad should her dad die and he's likely to, the family home is likely to be sold, she'll effectively be homeless and no doubt there'll be fairly some family disruptions and arguments. Margaret, when you were thinking about this vignette and clearly there may well be social services involved around the housing issue, there may be acute psychiatric services or there's the private psychiatrist, there may be drug and alcohol service, there's the psychologist. When you were describing that vignette, what was going through your mind about multidisciplinary care for this person?

Margaret Foulds (00:47:33):

I think the willingness of the person, it's a bit like the last one we're just describing to reach out. I mean this person has attempted, I've attempted with this person engagement with various services, drug and alcohol work support services because this woman is actually very capable. She's just so disabled and if that makes sense. And I think a crisis will come when her father dies, which could be any day. And that I suppose that fear about what happens with housing for someone who's on effectively new start and the expectations of the person for help may not match what's actually available and how that can match up with.

Dr Ruth Vine (00:49:01):

And so how does that play out in terms of how you might communicate with others who might be involved in her support?

Margaret Foulds (00:49:11):

Well, I think I am thinking about it because I've actually got return a call to psychiatric services tomorrow as like, this is real time, this is you. Okay, be in therapy Margaret, right? And you think, oh, am I even going to get onto the person who's been kind enough to ring me at a time when I too am available? I think it easily becomes kind of talking about the person rather than with them. I think there's this sense that can very easily slip into, we are going to take over and talk about this woman and they're going to want to know things from me that might be different to what she wants them to know or wants them to think about her.

(00:50:09):

And that's kind of natural. You can't actually explain someone to someone else. It's not that simple. So I think it's about understanding what the particular service needs in order to be involved or to help or to redirect the person. And then trying to direct the communication around that. I don't think it's so much taking up the whatever the always advocating what the wishes are for the person. I think helping them to advocate for themself and not necessarily championing the championing them because I think that can set up a certain dynamic with other services as well.

Dr Ruth Vine (00:51:10):

But what a critical thing that you've raised there. Well, there's two sides if you like of the same coin. There's the importance of information sharing. You want to tell other people what it is, but there's the absolutely critical part of the person that the person is. And we touched on this earlier, I think Michael, you touched on it earlier about what that person's choice might be at that time and what that person might feel ready or willing or able to share at that time for what purpose and that tendency that we sometimes have as professionals to want to give all of our view in a way without necessarily touching, touching with the person themselves. And in this instance, your person might have a crisis and might be in a very difficult position and not know who to contact or what to contact. Will your role then be, even though you're saying the person, it's best if the person advocates for themselves, what is your role then in facilitating that?

Margaret Foulds (00:52:25):

Well, I guess given my knowledge, I think it's about helping the service that she has engaged with at the moment to see what they might be able to offer her. It'll be a bit of a pitch. I actually think they could offer her something at this stage that might be really helpful to her in her treatment trajectory and knowing services whether they want to take that up. But I think if I can explain that and they can feel like they have a role in that that makes sense to them and seeing what the exit plan will be, then I think that that might help her and them to work together

Dr Ruth Vine (00:53:20):

To get through Tracey. These situations, the of person that Margaret's described particularly quite vulnerable at the moment, might have a crisis, might have issues on top of her coping mechanisms of using drug and alcohol as well as a family. Tell me how valuable a social worker is in this situation.

Tracey Hocking (00:53:44):

As you were talking there, Margaret, my brain's just going get a social worker, need a social worker. Because I think how a social worker can add to the value of the team in these kinds of situations is I think sometimes if people are working with people like yourself, Margaret in private practise or they're going to clinics and no one's got eyes on them at home, social workers sometimes can do that if they are funded accordingly. And in

that kind of service of course. And sometimes you go out with one perspective of you're going to be working with one person and then you end up finding another client inadvertently who you might end up supporting or pointing in right direction or getting some support for maybe this person's elderly father or whatever the case may be. Sometimes you think starting up in one part and you end up further down the road with several members of the family.

(00:54:47):

But I think that social workers can help with more of that systems view working in around some of those social determinants around whether it's housing, community, finances, all of those kinds of elements that really impact on people. I think one of the challenges I was just reflecting on as you were talking Margaret was, and I'm sure we've all come across this, is what do you do when there's nowhere to refer people? And that's unfortunately can be really challenging. And I imagine when you're in private practise, that would be very challenging if you've got people who are saying no when you're trying to make a referral or everyone's full, there's wait lists for everything. What do you do in those circumstances and do you hold or just what do you do? And that's something that's very difficult across a lot of different contexts I would guess because we're all over capacity and trying to do our best in difficult circumstances.

Dr Ruth Vine (00:55:47):

Well I agree. And Paul, I see you put your hand up, but in fact just before you chip in, one of the very regular criticisms shafted to acute services is that they fail to communicate adequately with the private psychologist or they fail to communicate adequately with the general practitioner. So when a person like this does turn up on a more or less regular basis in crisis to the emergency department or to the community clinic, what should the health service be doing? The psychiatrist if you like, be doing to ensure that degree of communication and continuity?

Dr Paul Fung (00:56:26):

I was thinking about the fact that there's a lack of flexibility within our system outside of a fee for service model to deal with this type of regular communication with other services and these life issues that all of our consumers have.

(00:56:52):

And I think that rigidity means that we do need to have some models which are either block funded or blended in some sort of manner to be able to do that communication with other services on a regular basis. And for me as a psychiatrist, one of the real challenges is knowing what services exist out there. And so using websites for example, like Ask Izzy or knowing that my PHN will have several resources on their website, maybe some commonwealth funded services that would be willing to take on a person like this means that they've just got a little bit more flexibility in terms of how they can provide a service without having to rely on fee for service, which is generally in private

Dr Ruth Vine (00:57:49):

Practise, which I guess in a way was the intention of what's now called the Medicare mental health centres, what was called head to health or head to health. And of course the New Zealand model is endeavouring to do that. The amazing thing is that our time has almost passed. And so what I would ask you in turn to do is just reflect a bit on, I guess what it's been like being part of the last hour, but if you could put into that reflection, I

feel like we've described a lot of things and we've given a lot of examples, but I dunno if we've necessarily provided terrific solutions. So just to bring your thoughts together about what do you think it's been like being part of this last hour, and Paul, I started with you at the beginning. So Michael, I might start with you this time. I'm going to have to ask you to be reasonably brief so that we all get around, but what do you think? Have we done a good job?

Dr Michael Tam (00:59:00):

I think we've done a good job. Yeah, no, I always find multidisciplinary team meetings fun because people from different perspectives talk about scenarios from a different lens. These are complex issues. If it was so easy to fix, we wouldn't have a problem. So it's normal in a certain way that they remain complex. But solutions are not simple. They are complex issues. I think in terms of things like block funding and things like that, there's many ways to skin a cat. I think the focus is probably better on principles, wrapping around care around patients. I think that as a really core principle, whatever the model of care looks like, the structures including funding should support that as opposed to necessary retro, say retrofitting things to a specific model. I think there are greater health system principles that often aren't spoken about within the mental health sector.

(01:00:05):

Like health systems are most effective when they're primary care focused. That's been around for a very long time. Mental health is special, it's important, but having a completely separate model to the rest of healthcare, I think it's a little bit unhelpful as well. Not breaking what's working. Australia has very good health outcomes, people miss out, but we still actually have very good health outcomes. So I think there are challenges with fee for service, but it keeps a lot of things afloat at the same time. And so we need to be careful. We don't end up breaking things in a sort of enthusiasm to make things better. But I think yes, it probably is a role for some form of block funding, particularly block funding focused on specific needs and particular population groups, but at the same time don't break what's already there.

Dr Ruth Vine (01:00:55):

Do you think, just, I have to pick your brain while we're here, but clearly the current government has put a lot of investment into urgent care centres and into increasing the bulk billing rate. Do you think that either of those things are likely to improve the sorts of things you were just talking about, which is integrating primary care at the centre of a complex system?

Dr Michael Tam (01:01:16):

Yeah, the reality is probably not. So the bulk billing increases will probably slow the decline, I think in bulk billing rates for maybe a couple of years or so. But it doesn't really address some of the fundamental structural issues and why it's occurring in terms of things like urgent care centres and I think some of the new Medicare head health type centres as well. The challenge again is the issue of integration. If they're not integrating back to mainstream primary care, they're set up as separate silos. You are sort of running against the grain on what we know is likely to work. So yes, I think there will benefit some people, absolutely no question about that. But is this going to lead to long-term system redesign and change that will actually make the whole system better? A little bit hard to see how that can be the case just because of the structural nature of it not really being aligned with the idea of a primary care focused cell system that's integrated.

Dr Ruth Vine (01:02:17):

Thank you. Tracey. How have you experienced the last hour or so?

Tracey Hocking (01:02:23):

Well, I find it very enjoyable to have a conversation and with like-minded people and talking and acknowledging as you say, Michael, that these are complex issues that we deal with. I think to put more solutions focus onto it, I think it's important that we acknowledge that they're complex and we name that and we are compassionate to ourselves that work in this sector. And sometimes we're really hard on ourselves that work in this sector. We work in what is often a really hard space because of the complexity of the system. But I think that naming it for a start goes a long way acknowledging that we're all working in a hard system. I think those relationships also would go a long way if we could lend ourselves to have that. But for me as well, I think once we continue to silo, to take your point Michael, around mental health, health, but also broadening that out. We silo community, we silo all sorts of things in our systems, but we need all of those to make a healthy individual and a healthy community and a healthy society. So in an ideal utopia, we would break down some of those barriers and look at it more broadly. But yeah, that's maybe two utopia. But I think that would be trying to look at some of the options around embedding communities and creating healthy communities to support each other.

Dr Ruth Vine (01:04:00):

But I guess some of the options that have been tried and that there are models in place where it's come from a different perspective. So things like the housing first model, which says, let's start with stable accommodation and then build the supports around it rather than, but you can always, as Michael said, there's more than one way to skin a cat. Tracey, I can't, again resist popping in a little special question here. I think you've worked in this area for quite a few years, haven't you? I have, yes. Do you think has NDIS been our saviour for multidisciplinary care?

Tracey Hocking (01:04:39):

I'm not sure I can honestly answer that. I dunno. There's some great work goes on. I think it's made it a little bit more difficult too, be fair. But there are some pockets of really great work going on because people had some creativity into it.

Dr Ruth Vine (01:04:53):

Good on you. Good on you. I think, I mean, one of the things of course that NDIS has done has perhaps made a multi provider system into a multi multi provider system. And as Margaret mentioned earlier, if you're going to have coordinated care, particularly where people might have very complex challenges, then having too many people around the table or changing cast around the table can actually make life very difficult. Margaret, how have you felt about the last hour?

Margaret Foulds (01:05:29):

Oh, surprisingly good compared to how I felt with my nerves beforehand. I think the importance of dialogue and communication, I think it's really important. I'm really heartened to hear other people reflect that as well. And I think the trick in the system is don't get in the way of people doing that. That's one of the key things that at a high level we've got to try and do. Whereas bureaucracy seems to just put things in that stop communication. And I don't think there are solutions. I don't think solutions are the solution to say something

crazy, but it isn't an ongoing process of working with anyone. And I think systems have to be geared to facilitating that, not setting up structures that we have to navigate at the coalface.

Dr Ruth Vine (01:06:39):

And I guess Margaret, as you are aware, one of the things that I was involved with was the evaluation of better access. And again, this was in a sense trying to bring, it was trying to improve access to psychological services, but it did it in a way perhaps that perhaps didn't, again, improve necessarily continuity. And it didn't necessarily mean that people were getting what was most appropriate for their needs. And I think that is shown in the outcomes. But we're go into that now.

Margaret Foulds (01:07:12):

Don't let the perfect be the enemy of the good, Ruth

Dr Ruth Vine (01:07:14):

That's right. It's not perfect indeed. Paul, for you.

Dr Paul Fung (01:07:20):

Yeah, look, I think primarily my role as an NGO provider, I think there is something about NGOs that can think creatively around money. You can pull together different streams of money to be able to do things that will span across those silos. So for example, in our NGO, looking at our mental health services and how they can be providing services to our early intervention child protection services, how they can be providing services to our homelessness services and how they can be providing support for our employment providers. All those things means that we are able to pull together maybe some other streams of government funding together to be able to make that work. Similarly, we also were able to pull a wellbeing clinician from our adult mental health centre within a general practise so that they were co-located within a general practise and that they were able to then provide some really strike while the iron is hot services for consumers that do enter general practise. So there are different models that can be tried when you think creatively around money, I think

Dr Ruth Vine (01:08:37):

Yes, but I think you are right. Of course, the creative thinking about money has to be creative in the best interests of the system, not in the best interests of the provider. And sadly, we do see entrepreneurial people who are out to make a profit from something that attracts government funding and that often distorts some of those models that we see. And Paul, in your, I think we've got about a minute minute left. In your travels, you mentioned New Zealand, but did you see a place where you thought, Hey, this could work really well in Australia?

Dr Paul Fung (01:09:15):

Yeah, look, I really thought that New Zealand was a helpful model for how you could place a wellbeing clinician and maybe a nonclinical person within a general practise and how that could then be connected to a specialty mental health centre like our head to health centres here. Because I think that the fact that we've got this parallel system of Medicare mental health centres or head to health centres in Australia, I think it poses a risk for holistic healthcare in general. And so how we actually connect that from general practise into these specialty mental health care centres, I think really requires a little bit of thinking. So I think New Zealand has done it well.

Dr Ruth Vine (01:10:02):

Yeah. Thank you. Thanks, Paul.

Dr Michael Tam (01:10:04):

Now, Ruth, I've been tasked with asking how you found moderating the group.

Dr Ruth Vine (01:10:11):

Oh, well. Okay. Thanks Michael. Well, firstly, I want to thank all of the people on the screen because it's been a delight being with you. You've all contributed terrifically and I think all brought up things. I think again and again and again, we do see that there are some common elements, and we've talked about some of those, but relationships between people having a respect for different professions and understanding, as Margaret pointed out, what the scope is, what's realistic expectations I think's been really important. I think we in Australia often do tack another bit onto something rather than think how quick can we change primary care in the way that New Zealand did their sort of change to primary care. Instead, we tack on a head to health or we take on a headspace or better access. But look, I think, I hope we've covered a lot of ground.

(01:11:09):

I hope people that have been listening have found this to be enjoyable. What I think we intended to do, but we'll hopefully get your feedback, was to talk about some of both the challenges, the hurdles and the enablers of cross-sectoral multidisciplinary care. Distinguish a bit between what different disciplines are willing and able to contribute. And I think we did that pretty well. It was terrific to have the psychiatrist, the general practitioner, the psychologist and the social worker with us this evening, and hopefully to give some tips and strategies that people can take away and use in their own and their own service. So please let us know in the feedback survey if we did manage to do any or all of that. And if it was helpful and what you thought about the format. We did do a bit of the vignette, a bit of the what ifs, a bit of the so whats, and of course, as I mentioned at the beginning, please remember that you can claim CPD points and you'll get a certificate of attendance to support this. So I think we're about on time. Thank you very much for being part of this and I enjoyed it. I hope you did too. Goodnight.