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National Workforce Centre for Child Mental Health

It takes a village: Understanding the drivers that facilitate interagency collaboration for improved mental health outcomes for children aged 0–12

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Introduction

This research, from May 2019, investigated the barriers and facilitators to mental health care pathways in the early childhood mental health sector, with the aim of better understanding the behaviours and systems that underpin service co-ordination across sectors.

The research used a place-based approach and engaged with early childhood service practitioners from the Barwon region in southwest Victoria[1]. Engagement methods included 23 face-to-face interviews; two interactive workshops, including one with 12 paediatricians; and a forum with 45 practitioners from across the service system and early childhood mental health service sector – a total of 80 participants.

Participants included the following:

- general practitioners
- practice nurses
- practice managers
- mental health workers
- parenting group facilitators
- kindergarten service managers
- paediatricians
- social workers
- Education Department student wellbeing managers; and,
- a child psychiatrist.

In the interviews and workshops the following questions were explored:

- With a focus on early intervention and prevention, what are the drivers that facilitate mental health referral and care pathways for children aged 0–12?
- What are the barriers to interagency/ interdisciplinary collaboration experienced by services in the Barwon region?
- How can we improve understanding between sectors/disciplines?

Report Summary

Across all interviews and workshops, common themes emerged about barriers and facilitators to referral pathways.

Barriers to service provision and mental health referral pathways raised included:

- waiting times for services
- cost of services and transport
- impact of social disadvantage on treatment adherence. For example, some families were struggling with basic needs such as housing, transport and employment, which impacted on

1 Detailed regional demographic data from the 2016 Census is available here.

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their ability to attend appointments
- eligibility criteria for services
- care burden and time restraints
- communication between service providers
- referral pathways, processes and systems; and
- working across sectors: information sharing and information systems.

Facilitators to improving referrals and collaborative partnerships for the benefit of children and families included six common themes, which all providers identified:

- co-located services or hubs
- 'stepped care' approach whereby the level of service provision aligns more closely to the needs of the client, similar to the intervention spectrum methodology
- support co-ordination and multidisciplinary teams
- an increase in services in early learning and childcare settings, such as parenting skills training and mental health education for families
- integrating schools as part of the health system; and,
- establishing trust and building relationships.

These themes formed the basis for 10 recommendations, summarised in Appendix 1. Six of the recommendations were either suggestions for the development of specific resources, or related to areas where advocacy at either state or federal level was required: for example, changes to the Medicare rebate system.

This article will focus on four recommendations or key areas for improvement for service provision, which rely on the need for quality relationships between health care providers at all stages of the health pathway. The four recommendations were:

1. Improvements to screening, assessment, triage and referral processes.
2. The need for support co-ordination.
3. Establishment of integrated community service hubs that enable co-location of primary, secondary and tertiary services with social and family service providers.
4. Educate health and social services to better integrate with schools and the education system.

Arguably, these four recommendations could not be fully operationalised without good working relationships, established and maintained between health care providers and the individual practitioners working within them. These relationships included those:

- between the service provider and the family and child (through simple actions like making follow-up calls and having time to listen and understand the needs of the child and their family)
- between service providers themselves (when providers had a relationship with one another – through established networks or co-location – the chances of a successful referral were greatly increased); and,
- between service providers, with regards to their understanding one another's services (including establishing reciprocal communication practices, particularly when a referral has not been successful, and letting the sector know when service offerings have changed).

There can be positions of power between disciplines – either real or perceived – which can impact on how professionals interact with one another. This can prevent professionals from asking questions of one another, which can impact on the provision of good care to families.

By asking some key questions and focussing on how to enhance relationships, mental health care pathways for children and their families can be greatly improved. Questions include:

- What is it that your service needs to ensure so the referral you are making is successful?
- What extra support or information do families need to negotiate the systems?
- What is their preferred method of communication between your services: phone, email, video conferencing or face-to-face?
- What can you do to support a family while they wait, that may be of assistance to them?
- When can you follow-up with them?

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What follows is a summary of these four recommendations and the role that relationships play in their successful implementation.

1. Improvements to screening, assessment, triage and referral processes

Practitioners and other health care providers were either using different screening tools, or none at all. There did not seem to be one assessment tool that had a universal language or approach which would have helped to quickly determine the level of intervention required for the child and family. This resulted in referrals to paediatricians or psychiatrists that were either deemed inappropriate, were incorrect, or did not contain enough information.

The research found that service providers and practitioners all needed a better understanding of each other's service offerings, associated costs, wait times, eligibility criteria and referral processes.

An instructive example can be given which was uncovered during the interviews: almost without exception, professionals across disciplines talked about their frustration in making referrals to the local acute child mental health service. These referrals were always made because professionals did not think that they had the required skills to work with a child whom they believed to be in crisis, and often at high risk. When this issue was raised with child mental health services, they too expressed frustration at the amounts of referrals they were receiving. Instead, it was their belief that so much could be done via an over-the-phone secondary consultation.

This was new information to the researchers, both of whom had worked in the region for over 15 years. Discussion in interviews and evaluation from the workshop forum also showed that there was no awareness of this secondary consultation offering. Instead, these professionals had been assessing their clients and making referrals to child mental health services, resulting in the child being placed on a long waiting list, when they could have continued to provide support to that child with a secondary consultation.

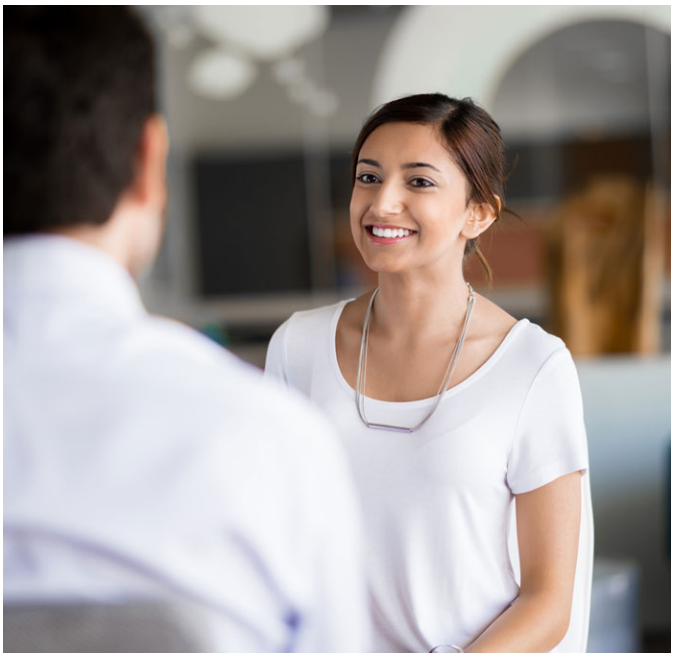
This example clearly demonstrates how improvements to screening, assessment and triage processes, combined with a better understanding of referral processes and service offering, would facilitate better health outcomes for children and their families. Arguably, better relationships across the sector would make way for clearer communication and understanding in all of these areas.

2. Support co-ordination

Without exception, across the health pathway there was a call for the creation of support coordination or a key worker model. Everyone believed that this was vital in helping families navigate and interpret the system. Crucially, over time, a support coordinator would also be developing relationships across the health pathway – relationships which were found to play a major role in ensuring a smooth journey through the system.

In services where multi-disciplinary team care was not achievable, or where services operated in 'silos', stakeholders described the critical need for a worker to play a role in supporting care co-ordination.

These support coordinators could also play a role in building relationships and facilitating the flow of communication into services, to ensure that the providers can develop an informed assessment and enable linkages between clinical and non-clinical interventions. Suggestions for workers who could provide support coordination included practice nurses, mental health nurse practitioners, social workers and child health workers.



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3. **Establishment of integrated community service hubs that enable co-location of primary, secondary and tertiary services with social and family service providers**

Those professionals operating in community hubs talked about the positive impact that these had on developing relationships between practitioners across the health care pathway, and how this increased their understanding of their colleagues and their disciplines. Practitioners also talked about the way hubs created opportunities for incidental conversations and quick consultations about client referrals or progress. Integrated hubs also generated more formal opportunities to create a community of practice, with regular case discussions for teaching and learning purposes easier to arrange.

The benefit to the child and their family was also recognised: integrated hubs provided them with a single entry point to a centralised service hub supporting multiple community spokes.

Digital Hubs Practitioners also suggested that a localised digital portal/navigation tool could be developed, which could include:

- a library of resources
- a list of services, including updated information about eligibility criteria, referral
- guidelines and interventions in a local area; and
- a directory of child health interested partners in the region.

4. **Educate health and social services to better integrate with schools and the education system**

Some people employed by the education system in student services and wellbeing expressed frustration that whilst they were well placed to support the interventions being implemented, external health providers did not always involve them in ongoing supports for the child. Although they may have made the initial referral and were working alongside the child's teacher, who outside of the family has the most contact with the child, they did not always feel as though they were as engaged as they should be. The suggestion was that improved communication and relationships between health services and the education system would lead to a more holistic intervention for the child.

This led to suggestions for more health and wellbeing supports in early childhood learning, kindergarten and primary school settings to assist in early intervention and prevention. This could include primary school nurses, social workers and mental health workers in schools. In-reach services could include GPs, paediatricians and allied health.

Conclusion

Practitioners may not be able to create physical hubs, or have the power to change or reinvent systems, but improving relationships with one another – between services, and with their clients – is a modifiable factor with flow-on effects for child wellbeing.

It might seem simple, but it is not simplistic – the *quality of relationship* between health care providers and with clients, at all stages of the pathway, is a key contributor to positive mental healthcare pathways for the child and their family. This is an element of practice that is not always funded or prioritised, and this can impact on the time and flexibility that professionals have to enhance or facilitate new relationships or networks. Yet the importance of relationships and communication was clear in this project. Increasing the ways in which child health professionals can interact, through networking events, topical round-table discussions or local forums, and valuing these activities makes a difference to outcomes for children and families.

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Summary of recommendations

1. Improvements to screening, assessment, triage and referral processes.

2. Support co-ordination.

3. Systems change and advocacy, including:

    - Medicare Benefits Schedule item number review

    - review remuneration of the existing workforce to support nurse practitioners and others to perform a support coordination role

    - review wording of the General Practitioner Management Plans; and

    - investment in telehealth infrastructure, including internet connections in rural areas and other connectivity system fixes.

4. Establishment of integrated community service hubs that enable co-location of primary, secondary and tertiary services with social and family service providers.

5. Develop resources for and in collaboration with parents and carers.

6. Educate health and social services to better integrate with schools and the education system.

7. Workforce development, including:

    - education about social and environmental determinants of mental health

    - needs assessment for vulnerable and complex families

    - trauma-informed care; and

    - develop a working understanding about stepped care approaches to childhood mental health problems.

8. Create formal and resourced networking and information sharing opportunities.

9. Advocacy for increased crisis intervention supports.

10. Family and carer centred approaches to planning and development.

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