

Current models of child and adolescent mental health service delivery

Vicki A Degotardi

Case management is inferior to a multidisciplinary team approach, where people can operate and be accountable within their specific areas of expertise

Child and adolescent mental health has been identified as an area of critical concern for the future wellbeing of our society.^{1,2} However, it remains questionable whether mentally ill patients and their families are receiving high-quality medical care consistent with modern practice standards and published guidelines.

Throughout Australia, the current public model of mental health care for children and adolescents uses generic mental health workers (case managers) who learn “on the job” rather than being required to receive specific psychiatric training and certification before they are employed. This case-management model permits young graduates from various courses (social work, occupational therapy, a bachelor of arts with a psychology major) to enter the mental health workforce and assume the role of an independent mental health professional. While such an approach may work in major metropolitan areas where sufficiently experienced senior allied health staff can provide supervision and on-the-job training to new graduates, it does not necessarily work in rural and regional areas where there may be few or no senior staff.

Under the current model, allied health professionals are expected to make diagnoses and to provide counselling and other therapies for which they may not have had any specific academic training. Such an approach is a far cry from holistic scientific psychiatric treatment based on a specialised skill set, and is superficial at best and potentially harmful at worst. Given the lack of prevocational training in specific child and youth diagnoses and treatments, supervision by a qualified child and adolescent psychiatrist is essential. However, under the child and adolescent/youth mental health service model in use, all case managers are expected to work independently and interchangeably with each other, including doctors, whose only unique role would appear to be writing prescriptions, ordering investigations, and excluding organic causes. Not all clients will be seen by a doctor, and not all recommendations made by a case manager to a general practitioner or patient will have originated from or be known to the psychiatrist. Yet it is the doctor (for example, the GP who writes the prescription) who bears the overall medicolegal responsibility.

Task transfer and substitution

A brief survey of the literature will indicate that doctors are not opposed to delegating to others tasks that were previously only carried out by medical staff.³⁻⁶ It is a practice that has been evolving over decades and centuries as skills and knowledge increase, and it will inevitably continue. However, “Poor economic outcomes arise when scarce resources are misallocated. To push the envelope on task substitution is to invite *poor* resource allocation. It is not a good use of resources to use health professionals in roles for which they are not trained and not expert.”³

Training and competence

Case management has been accepted in mental health service delivery in Australia now for over 20 years, although there is still no requirement to hold (or be training for) a postgraduate mental health qualification at the time of employment as a generic mental health worker. Instead, training is provided “on the job” (although without an apprenticeship), where knowledge and aptitude is never tested in any examination or formal assessment process. However, such an experiential approach to learning does not expose all workers to a set curriculum that ensures that all aspects of psychiatry will be considered in any one given case. No diagnosis can be accurate or trusted if the full range of differential diagnoses has not been considered, and no differential diagnoses can be considered without a comprehensive history taking and mental state examination. Without appropriate training, many aspects of a patient’s case history may not be recognised as important (or even elicited), and thus not be presented (or considered) at case conference. If the diagnosis is not correct, then any treatment plans based on it are useless. “The tragedy is that as our knowledge grows, our approaches to treatment seem to become simplistic, with psychiatric practice sadly becoming dumbed down . . . with a tendency to adopt a cookbook approach to our treatments and a lack of sophistication in the way we understand patient problems.”⁷

Workers operating beyond their level of competence will be appropriately anxious, but propped up by systemic reassurance. They will be unaware of what they do not know, ultimately lulled into a state of false overconfidence (a denial of the overwhelming reality of anxiety). “People tend to hold overly favourable views of their abilities . . . this overestimation occurs, in part, because people who are unskilled in these domains suffer a dual burden: not only do these people reach erroneous conclusions and make unfortunate choices, but their incompetence robs them of the metacognitive ability to realize it”.⁸

Conclusion

The case management model currently in use in mental health is now widely used and accepted throughout Australia. In some parts of the country, an attitude that all “mental health workers” are equivalent and interchangeable has developed, particularly among mental health administrative managers, but clearly this is not so in the eyes of the law and the public. I would argue that a multidisciplinary team approach provides a much safer and more efficient method of service delivery. Such an approach optimises the collection of information necessary for an accurate diagnosis, from which a high-quality integrated treatment plan can then be formulated. In reality, the current case management model tends to devalue the expertise of individual team members by forcing them

into generic skills that do not necessarily utilise their *specialist* skills. However, individual team members have much to contribute from their own specialties. A well functioning multidisciplinary team will provide comprehensive assessment and consultation, together with a forum for learning more about the strategies, resources, and approaches used by other disciplines, without the need for a case manager to play all of these roles. I believe we need less of a managerial approach in teams, with a greater focus on individual clinical input and accountability, through integration and coordination (rather than management) of expertise.

Competing interests

None identified.

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