National Centre
of Excellence in
Intellectual
Disability Health

Transcript: Collaboration across professions and services

Pramudie Gunaratne

Welcome. This podcast series is part of a larger intellectual disability mental health training program developed specifically for child and youth mental health services in New South Wales. I'm your host Doctor Pramudie Gunaratne.

Today’s episode is about services and collaboration and we’re speaking with Doctor Meena Rattan. Meena is a paediatrician based in Wyong Hospital and Westmead Children's Hospital.

Welcome Meena. Lovely to chat to you today.

Meena Rattan

Thank you so much for inviting me today. It's a great opportunity to be able to share my experiences.

Pramudie

Can you tell us a bit about your role and the service that you work for?

Meena

I work in Wyong hospital in Central Coast Local Health district, and I work in the staff specialist capacity and also just finished three years of my term as head of the department for Wyong hospital. So, my role basically is a multi-disciplinary team role where I work with other paediatricians, allied health, nursing staff, to provide care to the patients and families of Central Coast community.

My role in Children's Hospital Westmead, I would like to emphasize is very much aligned with the multidisciplinary approach which I have as I work an eating disorder team in an adolescent medicine unit. And finally, my role is also as a VMO at North Sydney Local Health District, again which is basically aimed at setting up paediatric services in Ryde Hospital.

Pramudie

Meena, we're very lucky to have your expertise on the podcast today. And we're focusing on children and young people who need support with mental health and intellectual disability health. And that's a really tricky landscape with all these different types of services and service approaches.

Can you tell us a bit about how mental health staff can navigate the different approaches, through different teams and different ways of working?

Meena

I think that's a very important question because there's a lot of confusion, especially not only with patients and families who are trying to navigate these complex systems, but also among the clinicians regarding the right approaches which these patients and families require. So there is, of course, doubling of resources and some complexity in terms of the criteria with which patients can access these services, which adds to the confusion.

As you know, there is a very fine line between behavioural paediatrics and mental health. So as a paediatrician, I have always felt that there is a growing need for us as paediatricians to understand that complexity and to provide our care and management plans and cater to the patient cohort effectively by trying to understand and help them to clear some of these confusions around access to health care in an efficient and timely fashion.

I think from that perspective only, I was very lucky to be a part of a project which came my way while working in Wyong called Paediatric Behavioural Triage Clinic. The focus and I think the bottom line of which was a multidisciplinary contact providing support and care to patients who have been struggling to have access to care with their complex needs, especially behavioural and mental health.

The other aspect which we highlighted during that time was trying to find whether there is enough information to those patients and families regarding the services which are available and how we can prioritize the vulnerable children and the children who are in need of these services effectively, in a timely way.

Pramudie

Meena, you brought up how sometimes services overlap with each other, and then it's hard to help families access care when they're sort of, there's two potential or multiple potential services that could provide that care. And there's also times identified where there's gaps. And so, patients and families fall through those gaps in terms of there's no service around to be able to provide that care. Do you have any tips for clinicians who might have either of those challenges in terms of overlaps and then they can’t access care or gaps and therefore can't access care?

Meena

I think this is really important and it can be resolved effectively with effective communication and trying to understand each other's roles and options or facilities, services, which each service is providing. I think there is lack of communication sometimes can be a barrier between two different teams, even to understand what would be the most relevant service which we can offer to the patients and families.

For example, even in Central Coast Local Health District we have community-based services which provide care to 0 to 5-year-old age group. Then we have Gosford Public Hospital as well as Wyong Public Hospital, which caters to paediatric population from 0 to 16 and not to you know, to add to more confusion, of course, there are mental health services, CAMHS services.

I don't think many families understand what is the reason to access CAMHS versus what is important to access other paediatric services. And sometimes that confusion leads them to come to emergency department to seek help in acute crisis. And that adds to the burden and resource utilization for busy ED departments, which could be easily avoided.

So what I feel is important is dissemination of information among different clinicians and also providing opportunities of patient contact and the contact with the families so that they are aware that with their needs, which agency will be the most suitable. And I think the pathway to that is through the community primary care providers, that is our GP's, who are usually the first point of contact for most of the families to providing more information to them. Making sure that there is availability of the contact details of those services and the referral criteria and the referral processes.

And at the same time, having more interdisciplinary collaboration between different teams and team members so that without adding on to more confusion, we are able to collaborate and provide comprehensive care to the patients through a single door entry - rather than making them go through different services themselves which can be tricky.

Pramudie

And from the point of view of a paediatrician, if mental health staff would like to be able to access paediatric care, are there particular types of information that it's helpful for mental health staff to provide to paediatricians in order to be able to access that care or sort of help paediatricians triage patients?

Meena

I think that would be very helpful because as paediatricians, most of our young people who have challenging behaviours have a history of vulnerability in terms of previous exposure to trauma, disruptive family, alleged abuse, neglect. And some of them, they are under the care of ministry. And there is a lot of history or family history of anxiety, depression and mental health, genetic loading, which makes it even more tricky. So if that information is available to the clinicians first on that, first of all, if we are triaging them effectively, and making sure that we identify whether the problem is mental health or it is something which falls in the scope of practice for paediatric care. And if we need support in managing some of those challenging behaviours without overloading the mental health services, which are more relevant for very specific group of patients, maybe we can actually create a collaboration between paediatrics and mental health on a bigger scale, which would be very useful for patients. And create a system of supervision or support for paediatricians to be able to effectively manage some of the patients which are falling in the grey area.

Pramudie

Do you have any examples of where that sort of arrangement has worked, or any teams that you've worked in where that's been successfully done?

Meena

Yeah. So I think the project which I mentioned briefly before that is Paediatric Behavioural Triage Clinic was a multi-agency, multidisciplinary project in which we as a group came together to support families in a very collaborative way. And I would like to give you an example of that project where the medical side was represented by paediatrics.

We had mental health representatives from CAMHS and mental health teams like Youth Health attending those multidisciplinary meetings. There was effective representation from other relevant agencies and services which are important for patients and families. For example, Department of Education, NDIS Disability Services, which provide support to the patients in terms of financial support. Then we also had representatives of DCJ and the community health services, because when we all came together, that was a clear example of how we can, you know, debate and collaborate to support those patients.

This was further enhanced by the presence of a care navigator, who was supporting the families to guide them in a step-by-step process. To find the relevant services where they can get assessments or management done, without taking too much time. And we also focused on the openness in terms of providing them options in both public system and private system and also giving them an idea about the waiting times so that they can get that can help them with informed decision making, to seek support for their children in an effective way.

Pramudie

That sounds like a really successful initiative. And if there are other teams that want to try and replicate something like that, can you tell us a bit about how it came about or how you developed that program?

Meena

I think that started with the trying and to help address the gap which was there between paediatric services and mental health services. And another reason was the growing waiting times in public system outpatient clinics for the patients and families who were on our waiting list for a very long period of time.

So it started with, trial of, we had some funding from the mental health services looking at supporting 0 to 12-year-old children with challenging behaviours or developmental issues. And we appointed a care navigator who was screening through our waiting list and identifying the clients. That was followed up by identifying which patients need to be prioritized. So, in terms of complexity and vulnerability, which we did through an effective ACE screener.

So there was a modified a screening which was done by the care navigator for each family and that helped us to identify the patients who need to be prioritized because of the complexity or vulnerability they were in. So, the patients with scores four and more, on ACE criteria, we brought them for an earlier appointment with the paediatrician. And the role of the paediatrician was to provide a very targeted, specific approach on those patients. And we did take the consent for the families, whether they want to go through this pathway. And we were very lucky that most of the families supported us in that initiative.

Pramudie

So, Meena, can you tell us a bit, you mentioned ACE and what that is?

Meena

Yeah. ACE stands for adverse childhood experiences. As you know, the evidence shows that children who are exposed to trauma or have adverse childhood experiences while growing up, they are the young people who are at higher risk of developing mental health problems and challenging behaviours. It also impacts their quality of learning and quality of life, long term.

So, ACE score is a modified way of scoring and recognizing those vulnerabilities and complexity in a timely way. And identifying all these vulnerable parties is given a score, which we then add up. And the literature shows that anybody where these scores are more than four are considered to be high risk, vulnerable children.

For example, anybody with parents who are incarcerated or, you know, their children are living in residential placements or are suffering from some severe neglect, their scores usually will be higher.

Pramudie

That makes sense. And what was the next step after that?

Meena

After the paediatrician gathered useful information from those families regarding all the issues they were struggling with. That information was brought to a platform with multidisciplinary, multi-agency representatives, and we debated about each and every patient and had input from everybody on that group that what relevant services would be useful for these families can be provided to them.

For example, if it was identified that this child needs extra support at school, the representatives from school were able to inform the school agencies and get that support identified. If it was some sort of disability issue where NDIS coordinators could be helpful, they checked whether that patient needed enhancing of their application in any way.

Similarly, we were very lucky to have DCJ and child protection representatives. So any child who was identified at risk, was linked with appropriate services. Parents, grandparents, support groups were identified by the community representatives.

Some of the agencies in the community, which can help with behavioural therapy or allied health interventions were also offered in that discussion. And all this information was communicated back to the families in a timely way by the Care Navigator. And not only it was communicated, but they were also given different time options, addresses, phone numbers, how they can access that information.

So, for example, if a patient has got challenging behaviours or they're struggling with their learning rather than sitting and waiting to see a paediatrician for years, they could start with doing some relevant assessments, getting some interventions. And by the time they come back for their routine appointments, a lot of work had already gone in which was useful in improving and enhancing their quality of life.

So this is just one example, but similarly any other child who has got child protection concerns and whether they were suffering from neglect, and that was the bottom line of their presenting complaint it was also very useful because the family got a lot of support. They were given housing and other strategies and supports which were useful for them to manage children and that overall translated in improvement of their symptoms even before they have seen a paediatrician for a routine outpatient appointment.

Pramudie

I'm just mindful that given all of these different services that are involved, it's tricky even for health care workers who understand the health system really well to navigate all of these different services. Do you have any tips for young people in their families when systems are really unclear how we can help them navigate that better?

Meena

I think for patients and families there needs to be more awareness and health literacy initiatives, which will help them to identify the right supports for their children. But I also feel that giving this information to the healthcare providers who, for example, it could be the community health nurse with which they have come in contact or their primary care providers will also go a long way in helping them navigate some of these tricky services.

But our project also proved that the role of care navigation is extremely crucial in supporting families in some of these complex dynamics because care navigator from a social worker background can be an asset to patients and families, and every service heavily depends on them because they can provide a lot of collateral information which the families may find very, very useful.

And clinicians being time poor with, you know, a lot of competing requirements of their roles sometimes may not giving a lot of information to the families which care navigators can provide.

I think from my perspective, care navigation has been very, very crucial link to the success of our project, which ended up being recognized at the federal government level. And we were lucky to get funding for evaluation. And I'm very proud to say that the evaluation was positive and that finally translated into more funding for our LHD to able to support these kind of clinics long term.

Pramudie

That's wonderful. You're absolutely right Meena. The role of care navigation sounds like it's so important. I know even with my own patients, they often say that navigating the system seems like a full-time job. So having someone who is specifically there to help with that navigation process sounds like a great idea. In terms of the team that you were referring to in the service, how often did the team meet?

Meena

We were aiming for at least once a fortnight clinic, and at least 6 to 8 patients were booked, but before they were booked to see me a lot of work had gone into the background by the care navigator in collecting all the relevant information which I needed, which included information from the school with their concerns, information from the parents doing an ACE screener, ensuring that they agree with the consent and sharing of information between different agencies because, you know for us, confidentiality and consent was extremely important.

And once the patients came on the day, I examined from the medical perspective and also took a brief history apart from the information which was available to me and put it all together for the multidisciplinary meeting which followed the clinic, where representatives from all the agencies were present.

And it was really cohesive unit by the end of this whole project, which went on for about one and a half year. It was really, really helpful because some of the referrals were being driven by the Department of Education or were driven by DCJ rather than our waiting list only. So which was really good to see that how it translated into gains for the patients and families.

And to be honest, in most of the patients we saw, since we were targeting up to 12 years of age, it was only one patient we identified who clearly had mental health problems. Rest everybody had challenging behaviours which could have been easily managed by paediatricians.

Pramudie

And Meena I can clarify you saying that you met the patients every two weeks, or was that the team that also met every fortnight?

Meena

The whole team met every fortnight because the clinic. So the clinic was followed by the multidisciplinary team meeting. Because every clinic we brought the information on the same day with the multidisciplinary team and all the recommendations which were done in that meeting, after the clinic were recorded by the care navigator and communicated back to the family.

And the care Navigator was also able to do progress phone calls and interactions with the family to see how they are going so that it is not a one-point contact with the family, but it is an ongoing till they get support or they come back for their comprehensive appointments.

Pramudie

It sounds like a really comprehensive and intensive program. And it's great that that was sort of led by paediatricians. I wonder if there could be similar services led by psychiatrist as well, with paediatrics input. So it sounds like maybe it's an area with is that overlap where paediatricians that specialize in sort of behavioural paediatrics. Then there's psychiatrist that also specialize in kind of behavioural parts of paediatric care. Whether there's that overlap there as well.

Meena

Paediatrics and psychiatry, there is a lot of collaboration which is possible even at the training level. Because I feel that College of Physicians, which provide paediatric training on the College of Psychiatry, there can be collaboration at the training level that all the paediatricians are upskilled.

So making changes at the ground level in terms of the training requirements of paediatric trainees and psychiatric training can be a great way of ensuring that we are mindful of each other's roles and responsibilities.

And moving on from there, only my role in Westmead Children is also a testament to the same collaboration because here I work with a psychiatrist and in specific group of eating disorders, there are a lot of behaviours which are not medical but need input from the psychologist and other allied health people. And similarly, the psychiatrist find it useful, the medical input whenever those patients have some symptoms because of the medical reasons.

So I think this is a great way to collaborate and identify patients with neurodiversity and intellectual disability, who are quite vulnerable, and we can work together to support their needs.

Pramudie

You're absolutely right. If we can start that at the training level, then it means we sort of understand each other's way of working and we can collaborate better. And I wonder even outside of, you know, doctors even in terms of allied health and nursing, whether there's opportunity for that collaboration right from training and also through working in services as well. The more we work together, the more we're likely to understand each other and be able to collaborate.

Meena

And I think the whole experience has re-emphasized the fact, which I already believed in, that multidisciplinary approach is the best way of providing care to our patients and families, especially when they have so many complexities and vulnerabilities, which is, I don't think that single clinician contact can do justice to their care.

So as a group, as clinicians, we have the duty of care to provide them comprehensive care, which is what they deserve. And the answer is collaboration between different team members to come together to provide them that support.

Pramudie

Agreed. So Meena, given how challenging the systems are, are there specific things that mental health clinicians can do to advocate for their patients?

Meena

I think advocacy for clinicians, on behalf of the patient is really important. The way the mental health clinicians and paediatricians can advocate for their patients and families is by giving them a voice at platforms. For example, at Ministry levels where their decision makers at executives are coming together and are collaborating with each other. So that they are aware of the area of need where they can provide relevant funding and support.

The other way I find is having some trials and projects, just like we had a small initiative which turned out to be really successful. So, encouraging those clinicians to be able to do something out of the box, which can turn out to be really relevant from patient's perspective.

And of course, the other way of advocacy is dissemination of information. So wherever something works for a particular group of patients that can be replicated and translated with more resources in another LHD and another set up. And I think, that can happen only if there is dissemination of information of these kind of projects and initiatives between different parts of Australia so that everybody can benefit from them.

Pramudie

That makes sense in terms of doing that broader advocacy around the system as well as the individual advocacy for each patient. In terms of the patient's and family experience, did they find that having a single point of contact through the Care Navigator was helpful compared to having to speak to a whole range of practitioners across the team?

Meena

I think that was something which was part of our evaluation of our project indicated that families found it extremely useful that care navigation as the single point of contact, who was gathering information from them and providing them with different options was really, really helpful.

The other thing which they felt was useful was that since the Care Navigator had all the background information, and there was no need for the other clinicians to talk about their trauma and vulnerabilities in that appointment, because we already had the background information. So it also helped them with their, you know, responses, and the focus during the appointment times, because we do not, especially with the parents with PTSD and mental health issues talking about their experiences can trigger a lot of trauma again for them.

So they found it very useful that the Care Navigator was there. The information from the school was also gathered by the Care Navigator. So I think the school also found a single point of contact to be useful, because sometimes they don't know where to send the information and that get lost in the system. So, I strongly believe that the Care Navigator was the backbone of our project success.

Pramudie

That makes sense in terms of having a single point where all that information is gathered and moves with the patient. And you're absolutely right about not wanting to retraumatize families by having to constantly retell their story. That sounds like another really great benefit of having the Care Navigator.

Meena

And I think some of the evaluation which involved taking feedback from the consumers really supported that fact that how useful this whole process they found. And how much time they saved from the time they came in contact with our project up to the time they got the right help for their children. And it was something they really appreciated.

Pramudie

And it sounds like it's an efficiency for patients in terms of their time, but also probably for the health service as well. It's, you know, a real gain to be able to help people in a much more succinct way as they move through the system.

It sounds like it was, you know, really crucial to have this care navigator role in this service that you've described. I guess a lot of CAMHS services may not have the capacity to be able to have a specific care navigator. I wonder if there's a role for, within the CAMHS services to have someone who sort of takes on that role.

Meena

I think of CAMHS services, the mental health nurses, or any clinician which is able to gather information from the patients and families because they need to have social work kind of background. And I feel in CAMHS services, the structure may involve some mental health clinicians or nurses, which can do this role very effectively because, you know, you just need to work and gather the important information. So I think this role can be played by any health professional, or allied health working in mental health team, as long as that is their dedicated role and they understand the scope of their role to ensure confidentiality and taking consent from those families to gather all the relevant information.

Pramudie

That's been a really great discussion, Meena. Was there anything else that you wanted to add in terms of things that we might have missed out in this discussion?

Meena

What I really want to emphasize is the collaboration between paediatrics and mental health services, which I find is going to be the future of paediatrics - especially in providing the right care to neurodiverse children who have intellectual disability.

And there is so much overlap, between their anxiety, which is considered as a mental health issue versus, you know, behavioural issue. So I feel the collaboration between paediatrics and psychiatry will be very, very helpful. And again, collaboration between paediatric services and mental health services at ground level can help achieve that collaboration in a more effective way.

Pramudie

That was really beautifully said. Thank you so much for joining us today, Meena. It’s been a real pleasure to have this chat with you.

Meena

Thank you.

Pramudie

Thank you for listening. This training program has been developed by 3DN, part of the National Centre of Excellence in Intellectual Disability Health and the Academic Unit of Infant, Child and Adolescent Psychiatry Services at UNSW. in partnership with the Developmental Psychiatry Team at Sydney Children's Hospitals Network. These podcasts form the advanced level of this training series and follow on from our e-learning modules and webinars.

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