

Collaborative Therapy Program

A.C.T.

Information submitted by:

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Background

This initiative was first introduced by Mental Health A.C.T. in May 2002 and is still operating.

Aims and objectives

Collaborative Therapy (CT) is a comprehensive therapeutic framework for consumers, clinicians, services and others to work systematically towards the achievement of optimal health outcomes. It incorporates service systems, health care providers and collaborative partners to ensure that the intervention is therapeutic and so is the system supporting it, thereby sustaining longer term optimal health outcomes. This initiative aimed to roll out a measured relapse prevention programme for adult consumers of Mental Health ACT.

Target groups

- All adult male and female consumers aged between 18—65 years who wish to be involved;
- Employees of Mental Health ACT, GP's and private psychiatrists;
- Other service providers; and
- Carers and significant others.

Project Infrastructure

Lead agencies

The Mental Health Research Institute of Victoria (MHRIV) and Mental Health ACT (MHACT)

Sectors and settings

- Mental Health ACT Acute and Community Services Program;
- Mental Health ACT Consumer and Carer Representatives;
- Mental Health Rehabilitation Service;
- The Crisis Assessment and Treatment team;
- Private consultant psychiatrists;
- Mental health registrars;
- The Division of General Practice;
- The Hospital Liaison Nurses; and
- Mobile Intensive Treatment Team (MITT).

Collaborations, partnerships

The initial partnership was developed between the MHRIV and MHACT. MHACT dedicated a clinical position to the establishment of Collaborative Therapy and the MHRIV provides the Collaborative Therapy model and will evaluate its effectiveness.

Processes

- Focus groups of consumers, carers and clinicians set up;
- Clinical pathways developed;
- CT Manuals printed for ACT clinicians and consumers;
- Delivery of CT and 'train the trainer' workshops to clinicians;
- Clinical supervision provided for clinicians conducting CT;
- Consumer qualitative feedback mechanisms established;

- Clinician Led Interest Group (C.L.I.G.) established as a forum to discuss the CT model, share experiences and help inform MHACT executive about ongoing interest and effectiveness;
- Monthly contact between ACT CT supervisor and CT co-ordinator MHRIV.

Reference, advisory or management groups.

- MHRIV and MHACT CT Reference group: monthly teleconference;
- Clinician Lead Interest Group;
- MHACT CT Management Group (consisting of Acute and Community Services director, MHACT CT Coordinator, CT MHACT assistant manager): monthly meetings;
- MHACT Coordinator and MHACT CT manager meet weekly.

Consumer and/or Carer involvement

Consumers are the pivotal part of the CT process and their participation is paramount. Collaborative partners are chosen by the consumer and can include their G.P, carers, family members, friends, clinical manager, etc. Consumers take part in the nine sessions of collaborative therapy.

Staff/ personnel (including volunteers)

- Co-ordinator (responsible for training new staff, ongoing supervision of clinicians practicing CT and program evaluation);
- Employees of MHACT :clinical managers; rehabilitation staff; nursing; medical and allied health staff;
- The Division of General Practice Mental Liaison Nurse; and
- CT Unit of MHRIV.

Personnel training

Staff are trained in the CT model and in group work as necessary. General Practitioners and other treating specialists have been offered information session on the CT process.

Initial funding

Mental Health ACT has funded a dedicated clinical position to coordinate the introduction of CT in the ACT. Staff training has been funded by the staff development fund of MHACT. Some additional monies have been spent on the printing of manuals and the CT diaries.

Funding sustainability

The coordinator position for the CT model is expected to continue for the next few years whilst the roll out continues, and will be conducting reviews of the processes and outcomes.

Implementation

Detailed description

Collaborative Therapy consists of three core generic components:

- Education;
- Coping Strategies; and
- Skills Development.

Participation in CT may be group based or 1 to 1 intervention. Group work consists of:

- Introduction to CT;
- Introduction to Stress Management;
- Stress Monitoring;
- The Stress Vulnerability – Self-Efficacy Model;
- Early Warning Signs;
- Coping Strategies for Daily Self-Management;
- Developing Constructive Coping Strategies;
- Implementing Coping Strategies for Relapse Prevention; and
- The Relapse Profile.

The CT technique is taught to clinicians across four adult community mental health teams in the ACT. CT groups have been established and are ongoing at two sites, and the other two sites will commence groups

in early 2006. One to one sessions have been conducted at all four sites. One to one sessions and groups are also being introduced at the Brian Hennessy Rehabilitation Centre.

Resources

Models

The main philosophy of Collaborative Therapy is based on the self-efficacy model, or the “You can do it” approach. It has been designed as a service delivery model. The self-efficacy model helps an individual to estimate or formulate a personal judgement of his or her own ability to succeed in reaching a specific goal. The model uses a visual description to describe the concept that a person can be at the centre of their health by having control over areas of their lives that contribute to maintaining that health.

Tools

Resources include clinician manuals, consumer workbooks and the pocket sized CT Journal (CTJ). MHACT have templates for these resources available via an internal shared electronic folder.

Clinicians are taught how to conduct the M.I.N.I. assessment tool. Electronic copies are available on a shared computer drive.

- **Collaborative Therapy Factsheet:**
<http://www.mhri.edu.au/pdf/FS08CTU.pdf>
- **Conference presentation “Collaborative Therapy: A Systematic Approach to Service Delivery & Therapeutic Interventions”,** Prof D. J. Castle and M. Gilbert. Includes: **My Health Plan: Collaborative Strategy Plan**, slides 24 & 25.
http://www.carersnetwork.org/doclib/conf-archive-2005/Castle_David.pdf

Outcomes

Relationship to 4A’s framework

The following information provides details of project outcomes as they relate to the major components of the 4As framework. This is a model developed by the Australian Government to support an understanding of recovery based approaches.

(For more information about the 4As: go to summary sheet at http://www.auseinet.com/files/factsheets/recov_summary05.pdf)

Awareness: *involves developing an understanding of one’s mental health needs, including specific knowledge of risk and protective factors. Includes education, stigma reduction.*

Collaborative therapy teaches coping skills to help maintain health and prevent relapse. The ‘coping strategies’ component is based on a strengths model, helping consumers to identify existing coping skills. The use of the treatment journal enables consumers to chart stressors, early warning signs, coping strategies, supports and other factors that influence the course and management of their mental health.

Anticipation: *processes which support people who have been seriously affected by mental illness to make their own decisions rather than to have decisions imposed eg: discharge, recovery, crisis plans.*

Consumers are encouraged and assisted with formulating their own health care plans and identifying their own collaborative partners to assist in maintaining better health outcomes. The journal assists in charting decisions made for management and treatment.

Access: *timely access to the whole range of services that support wellbeing and early intervention in times of increased service need. Includes service collaboration and partnerships.*

Collaborative Therapy focuses on the identification and development of collaborative partners in the individual's support network. Partners chosen by consumers are not limited to the public mental health system and may include any one identified by the consumer.

Alternatives: *recognising the need for an expanded range of treatment and community support options for people who have experienced mental illness eg: housing, employment, holistic treatment.*

The consumer's journal places the consumer at the centre of their treatment by facilitating communication with those who are involved in the maintenance of their mental health. There is also the potential for consumers to take their journal to other forums. In this way the journal knits together the various service sectors that consumers engage with and facilitates consumer empowerment and service integration over a lifetime.

Evaluation/Outcomes

What worked well?

- Consumer identification of collaborative partners;
- Consumer focus groups and associated consumer take up of the model;
- Choice for consumers between one to one or group sessions;
- The partnership between a research body (MHRIV) and a public mental health service;
- The ACT Mental Health Coordinator Position; and
- Train the trainer workshops for MHACT staff.

What have been the challenges or barriers?

Timeliness: a coordinated, slow roll out of the project has had the best results for staff engagement.

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