Submission to the Productivity Commission regarding Social Services

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## Effective focus of service delivery: Putting the real issues at the centre

I believe ***focus on social issues*** affecting people and their families rather than a focus on diagnosable mental disorders in (1) funding (2) service delivery, and (3) work force training would be a paradigm shift in the social service sector which would improve the beneficial effect of the social services that deal with those disorders and issues. I believe that such a shift is justified and would be undergirded by a broader and more relevant approach to the scientific evidence regarding treating social problems.

Many services are funded in a way that emphases mental disorders (e.g. conduct disorder, depression, anxiety, or psychosis) rather than the social issues that cause and/or maintain them and their co-morbidities (e.g. domestic violence, attachment issues arising out of neglect in childhood, or lack of parenting skills). Such focus on mental disorders, ***which I consider a focus on superficial symptoms*** rather than on client's holistic problems and causes of personal and family distress, is often referred to as a 'medical model' approach. Funding that targets mental disorders (i.e. medical model) is tied to an 'evidence base' which is based on that model and itself estranged from the realities of the practice world. The practice world cannot deal with isolated mental phenomena, but must deal with the whole client in their social setting and social systems (bio-psycho-social-spiritual model, or Te Whare Tapa Wha model) if it is to effect significant and lasting change. This disjunction between much of the evidence base in psychology and the realities of the practice world has been long recognised in the practice literature (e.g. Persons, J. B., 1991), and, indeed, the disjunction between the evidence base for many professions and their practice realities has been long recognised (Schon, 1987).

For example, the 'evidence base' of randomised clinical trials (RCTs) for cognitive behaviour therapy (CBT) tend to focus on just the one diagnosis (e.g. major depression disorder or an anxiety disorder) in their attempt at scientific homogeneity and rigour, but in doing so

remove from their participant samples the very people most like those who actually use social services, i.e. those with complex needs and multiple psycho-social morbidities (e.g. a meta-analysis investigating the effectiveness of interventions for psycho-social problems in cancer patients identified that CBT intervention studies used non-complex but highly motivated participants much more than studies of other intervention types: Heron-Speirs, H. A., Harvey, S. T., Baken, D. M., 2012a; Heron-Speirs, H. A., Baken, D. M., Harvey, S. T., 2012b). Therefore, although CBT may 'look good on paper' its usefulness with 'real-life' clients may be quite limited, and yet 'the evidence' may constrain services to use this intervention type and/or may result in resourcing for only enough sessions (typically 6-8) in the mistaken belief that this is the appropriate evidence based 'dose' required to treat the client's problems. Typically, the reality is that complex family dynamics, relational skill deficits, traumas, losses, co-morbidities etc. need to be addressed, and there is no possibility of even beginning to address them in such a short time, or with the input of only one professional.

This disjunction between intervention research and practice in the psycho-social sphere is not recognised in the way that the social service sector is organised or funded. The result is that many critically important services are resourced according to a medical model style 'evidence base' and have ***parameters that are consequently artificially and unhelpfully constrained to dealing with 'disorders' rather than the social issues that drive them***. Furthermore, important parts of the helping profession ***workforce are trained to focus on 'disorders' rather than on social issues***, and this limits their usefulness as well as the efficacy of the whole network of social services which relies upon them.

An important example of this is clinical psychology: clinical psychologists are trained to focus on disorders and treat them according to the 'evidence base', as described above. *Sometimes* the best treatment according to the 'evidence base' includes addressing family dynamics (e.g. in the case of anorexia), but most often it constrains clinical psychologists – notably those employed by services resourced to treat diagnoses – to target disorders in the individual as if the disorder were an isolated entity entirely bounded within that individual, rather than a product of, and contributor to, a family and/or other social system(s). In my personal experience (as a general psychology intern who has done most of the clinical papers), psychologists are taught to carve out a limited 'do-able' chunk of work to treat according to the resource allocation of their service, knowing full well that the 'real' issues – such as historic sexual abuse and lack of an understanding of interpersonal boundaries – are

not being addressed. We are taught not to 'take the lid off' underlying structures if we don't have the funding to address them. Our work can thus be constrained to be quite consciously superficial. Likewise, psychiatrists come from a 'medical model' perspective and tend to focus on medicating disorders rather than addressing the psycho-social issues in the patient's wider social context.

Psychologists and psychiatrists are key parts of the social service network, especially when psychological symptoms are severe, yet the medical model that often constrains their work can thus divert resources into assessing and treating disorders while leaving unaddressed the significant social issues that are fuelling them. Indeed, often no more is done than assessing disorder, and, possibly, attempting to medicate it. This can be very frustrating – for psychologists and psychiatrists, and for other social service professionals – who feel that broader and deeper causal or maintaining issues are not being addressed, resulting in the relative failure of such treatment as is provided (i.e. limited and/or temporary effect), and the continuation of major problems for the person and their family. Indeed, those problems may even be exacerbated by a sense of failure associated with the psychological/psychiatric treatment, and associated lowered self esteem or loss of hope.

Furthermore, university training may be devoid of significant training in the dynamics of major causes of much psychopathology, because of a narrow focus on diagnostic categories. For example, I was not taught the general dynamics of domestic violence or of child sexual abuse, although I was taught that these factors are predictors of much psychopathology, and I was taught techniques for treating the mental disorders that are amongst their sequelae. I have had to fill these important gaps in my education myself. And I have recently seen work by a CYF social worker who was dealing with a child welfare situation who clearly had no comprehension of the dynamics of domestic violence underlying the case. I have also been alarmed to discover that Family Court lawyers get no training in domestic violence and sexual abuse, but 'learn on the job'. I fear that Family Court judges may be no better equipped, and I note that the recent 'People's Report' by the Glenn Inquiry finds that the Family Court system is "broken" in terms of its ability to cope with domestic violence. This on-the-job training model essentially means that professionals are learning at our clients' expense – the expense of innocent children and abused women.

In reality, the kinds of issues that need to be identified and dealt with are usually holistic and grounded in family systems. They require longer and more comprehensive intervention,

delivered by multiple disciplines. The cost of such intervention should be seen as an investment in diverting the family from future expensive and intergenerational problems. In my opinion, the broader social issues that really need to be addressed in workforce training and in social service structuring and resourcing include:

- Domestic abuse and violence (suffered or witnessed as an adult or as a child)
- Sexual abuse (suffered as an adult or as a child)
- Emotional and/or physical neglect or abandonment (suffered as a child)
- Lack of intra- and inter-personal boundaries
- Lack of parenting skills
- Identity problems and/or lack of belonging (e.g. lack of whakapapa)
- Lack of values and/or spiritual base (which may include lack of connection to the land)

There is much overlap in the psychological morbidity that can arise under each of the above groupings, but it includes affective disorders, psychosis, personality disorders, relationship breakdown, social disconnection, addictions, and compulsive lifestyles. Other social issues that cause or significantly contribute to a great many problems are:

- Lack of quality social support and loneliness
- Lack of education (including literacy/numeracy) or vocational skills
- Poverty
- Organic psychiatric or medical issues or disabilities associated with psycho-social problems (e.g. traumatic brain injury, psychiatric diagnoses with a strong heritable component such as ADHD, chronic illness, obesity or other diet or lifestyle-related conditions)
- Marginalised culture resulting in exclusion/barriers and ongoing micro-trauma from discrimination (e.g. associated with ethnicity or sexual orientation)

So, in my view, the target of intervention should be social issues affecting the client and their social system (usually their family/whanau) rather than mere diagnoses focussing on the individual, because it is these broader issues in their broader context that are the real drivers of psycho-social problems. Furthermore, the infra-structure of intervention needs to be realigned accordingly. This means that (1) provider funding, and (2) work-force training should be reconfigured to target those issues. Funding realignment should encourage the

cooperation of multiple disciplines, whether within the one provider, or as collaborative work between multiple providers, to enable the targeting of systemic issues in the presenting client's family/whanau/other social system (e.g. school). Work-force training realignment should not only ensure that the dynamics and treatment of underlying social issues are taught, but also that the different professions understand each other's domains of specialty and how to engage each other's strengths for the benefit of the presenting client and their family/whanau.

In a social service system such as the one I propose, when a client presents with anxiety, for example, the underlying dynamics driving that anxiety would become the immediate focus, meaning that they would be screened for, rather than, or in addition to, screening for psychological disorder. If, say, those dynamics included current domestic abuse and some alcohol use issues, funding and service configuration should allow for the long term comprehensive treatment of the family, addressing the drivers of these problems. This would include such interventions as personal and couples/family counselling, parenting skills training, attending to developmental and medical issues, attending to educational and vocational training needs and associated poverty and lack of self-esteem, treatment of addiction issues, attending to lack of identity and values base, ensuring available community resources and government funding are tapped, and possibly legal intervention for the protection of victims. Unless such comprehensive work is done, the real problems will continue to produce dysfunction, and will reproduce and cause other problems inter-generationally, ultimately causing unnecessary cost to the state and unnecessary cost and suffering to all of the people in the affected family/social system.

As part of the funding regime that would sustain such an approach, a more sensible attitude towards the research 'evidence base' is required, along with flexible and holistic approaches to accountability data. The appropriate approach to evidence, in my view, is to utilise the broader concept of scientifically based 'principals'. This would broaden the 'evidence base' to include ***theoretical principals that are recognised and established by a more general research base*** than just intervention RCTs – it would broaden it to include all ***'psycho-social knowledge'***. And accountability data would be more meaningful if the emphasis was on meaningful engagement with change, i.e. gaining new insights, learning new skills and improving functioning, as individuals and as family systems, not just reducing scores on a distress screening tool.

These suggestions involve a paradigm shift regarding the recognition of broader psycho-social knowledge and the targeting of social service intervention. They also require a fundamental shift in how the various aspects of the workforce are trained and work together on the ground to address the more meaningful targets of intervention.

**References**

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