Gatekeeper Versus Concierge: Reworking the Complexities of Acute Mental Health Care Through Metaphor

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Gatekeeping is a term associated with the intake function of acute mental health services and involves making key decisions about provision of service to clients. The term can also be seen as a powerful metaphor, invested with both functional and symbolic connotations epitomising the challenges and dilemmas faced by acute care workers. The gatekeeper metaphor is explored and juxtaposed against an alternative metaphor, that of the concierge, which presents a more constructive and inspiring vision of clinical practice. Defensive, self protective and aggressive practices are challenged whilst clinicians are urged to empower themselves by moderating a growing focus on administration, control and risk management through renewed perspectives based on clinical judgment, compassion and care. Intake is redefined as a client focused service and the 'Concierge' a way of envisaging a more satisfying professional role for mental health nurses and other acute care clinicians.

'The gatekeepers are vulnerable though they pretend to stay in control'
(Excerpt from *Gatekeepers* by Henry B Stevens, 2004)

Introduction

The author has over thirty years experience in mental health nursing; much of that time in acute care settings. A participant observation approach (Douglas 1976) provides the basis for critical analysis of contemporary mental health acute care practice based on the author's professional journalling along with the reflections of other acute care clinicians. This ethnographic material is supplemented by content analysis of relevant literature.

Australian public mental health services utilise a single point of entry based in acute care teams; with the intention being to streamline intake processes and expedite initial determinations about service provision (Sands 2007: 243). Clinicians working in this role are required to weigh clinical and risk considerations against consumer perceptions of need (Vine 2011), societal (Mental Health Council of Australia [MHCA] 2005: 33) and organisational expectations (New South Wales [NSW] Auditor General 2005: 2). Add to this, constraints on time and resources, ethical and medico-legal considerations, along with a raft of documentation and accountability requirements (Mullen et al. 2008: 85; Deutsch and Rosse 2009) and the process starts to become quite complex. Although all health care decision making is influenced, or hindered (Forster 2005: 56) by non-clinical factors to some degree, tensions arising from these competing considerations converge most noticeably during mental health intake. It is during mental health intake that first impressions are made, the relationship with the consumer begins and the interface between the mental health service and the community is at its most public. In this context, acute care workers come to be viewed as gatekeepers deciding the 'who', 'how' and 'what' of service provision.

Lessons learnt from clinical practice should inform the theories that drive organisational mental health reform (Nolan 1993). Nearly ten years ago a discussion between acute care colleagues about the implications of the gatekeeper function sparked a reflective process that eventually resulted in this article. The conclusion of that original discussion was that the term 'gatekeeper' conveyed an administrative, service-based orientation rather than a clinical or consumer focus. The language we use as clinicians not only frames our self view but can limit our functional capacity and construct consumers in ways that support unhealthy paradigms (Summerfield 2001: 148; Hamilton and Manias 2006: 86; Wand 2013: 287); even contributing to the stigma of mental illness (Sartorius 2002: 1470; Hocking 2003: 47). Acute care intake workers faced with competing pressures, ideological and clinical dilemmas and without adequate support and governance, can resort to defensive practices designed to serve and protect themselves and the service, rather than the consumer (Lakeman 2006: 396; Mullen et al. 2008: 85; Deutsch and Rosse 2009). Adopting the concept of the gatekeeper as a metaphor might help us to reflect on the ontology of the acute care role in mental health whilst consideration of an alternative metaphor, such as the concierge, provides an opportunity to review and re-define strategies for promoting best practice (McAllister 1995: 397).

The Evolution of The Gatekeeper in Australian Mental Health

It has been postulated that it was actually economic rationalism rather than clinical or ethical considerations that eventually propelled the rapid move towards deinstitutionalisation in the 1980s (Baldwin 1990: 211; Treatment Advocacy Centre 2010: 2); while failing to allow the development of infrastructure required to support such a shift to community care (Ozdowski 2005: 203; Ibell 2004: 206; Green 2003: 6). This legacy has ongoing implications for mental health care to the current day (Senate Select Committee on Mental Health [SSCMH] 2006: Chapter 2; Fakhourya and Priebea 2007: 314), with the result that 'essential services are overwhelmed by the heavy demand they face and they are not able to provide the level of care and support required to assist recovery … ultimately, it is a failure of systems which is making people sick and is forcing them into the costly acute care sector' (MHCA 2005: 43).

The way society, and indeed medicine (Pridmore 2013: 1), views mental illness has also changed. Acute mental health services now deal with a range of emotional, situational and social crises not formerly identified as mental illness (Summerfield 2001: 149; Pridmore 2013: 1). In addition, an ageing workforce and shortage of experienced mental health trained staff remain a major concern (Duggan 2007; Vine 2011; Acherstraat 2011: 2). Currently, with some of the burden of mental health care transferred to primary health care providers (Commonwealth Department of Health and Ageing 2009: 11), many public acute care services now focus on triage and assessment rather than short term intervention and brief therapy, often leaving consumers dissatisfied (Victorian Heath Department [Vic Health] 2007: 11).

This raft of competing extra-clinical pressures also influences decisions about psychiatric inpatient admission (NSW Auditor General 2005: 8; Vic Heath 2007: 11). Relatively few people actually want to be admitted to a mental health unit [MHU], however 'the extent to which appropriate care can be given within a community approach is very sensitive to resource constraints and work practices' (Queensland [Qld] Health, 2005: 3). Most MHUs run at full capacity, focus primarily on containment and risk management, and provide little therapeutic treatment apart from medication (Leung 2002: 33). Consumer perceptions are that MHU nurses are overwhelmed by their workload and, consequently, unavailable and burnt out (SSCMH 2006: 6; Bee et al. 2008: 448). Due to increasing pressure on MHU beds (NSW Auditor General 2005: 2), patients may be discharged to make room for other patients rather than for clinical reasons (Capdevielle and Ritchie 2008: 164). Without effective, integrated community-based acute care, however, the risk of adverse outcomes (Qld Health 2005: 20) and readmission is significantly increased (Heggestad 2001: 196; Kalucy et al. 2005: 74; Wallace and Corderoy 2011; Hyland et al. 2008: 4; Zhang et al. 2011: 582). For example, studies cite 28 day readmission rates of 14-15% (Hyland et al. 2008: 8) with annual readmission rates between 30% (Hyland et al. 2008: 8) and 46% (Zhang et al. 2011: 582).

In acknowledging the influence of economic (Ibell 2004: 198; Capdevielle & Ritchie 2008: 164), organisational (MCHA 2005: 37), and political (Ibell 2004: 257) factors on mental health service delivery, it is important to clarify that whilst ongoing mental health policy reform is necessary at state and federal level (Rosenberg et al. 2009: 194, McGorry 2010) there is a corresponding need for workplace practice and culture to be addressed locally (Forster 2005: 56). The reactive implementation of change, in response to critical incidents and adverse publicity, has resulted in a proliferation of corporately driven risk management mechanisms (Qld Health 2005: 22; Forster 2005: 168). Whilst individual accountability is important, the effect of increasing administrative and documentation processes is less available time for clinicians to engage in meaningful, therapeutic contact with consumers (Drake et al. 2001: 180; Cleary 2004: 57). The resulting theory-practice gap can challenge the integrity and ideals of the caring practitioner (O'Brien 1999: 156) and can lead to the development of stereotyped, administratively driven practices and beliefs that can end up becoming entrenched in workplace sub-culture. In what might be considered parallel process on a systemic level, clinical aspects of acute care can also become reactive and self-protective (Lakeman 2006: 396). Teams can develop a 'siege mentality' where the main goal is protecting the work group from perceived threat. Unless acknowledged and addressed, this defensive position can result in the ultimate embodiment of threat becoming the consumer, particularly those consumers with complex needs, abuse and trauma driven behaviours, drug and alcohol co-morbidities and those who frequently present in crisis. These consumers tend to reinforce clinician frustrations and perceptions of powerlessness resulting in group counter-transference and activating the self-protective energy of the team. In acute care settings, the manifestation of this phenomenon is most easily recognised in the framing of clinical interventions in defensive terms such as 'diverting a referral' or 'giving someone the flick'.

The medicalisation of public psychiatry (Szasz 2001: 510) has also contributed to an erosion and devaluing of interpersonal aspects of mental health nursing practice (Barker 2003: 96; Gilburt et al. 2008: 181). It is a matter of concern that research has identified clinical skills deficits in areas such as rapport building, engagement, and communication in general (Fraser 2005: 33; Gilburt et al. 2008: 12; Bee et al. 2008: 451). Factors such as these are accepted as predictors of a positive outcome in psychotherapy (Lambert and Barley 2001: 357) and key elements of the recovery model theoretically underpinning current mental health practice (Johansson and Eklund 2003: 340; Barker and Buchanan-Barker

2008: 13). Interestingly, a meta-analysis of mental health service user surveys noted that consumers generally perceived mental health nurses positively as 'a multi-faceted role in which practical and social support are provided alongside more formal psychological interventions' (Bee et al. 2008: 451). However, service users attributed inadequacies in the delivery of mental health inpatient nursing care to a combination of the 'damaging impact of high staff turnover, high staff sickness and an organisational reliance on agency staff' as well as negative staff attitudes and lack of availability (Bee et al. 2008: 451-2).

Gatekeeper Versus Concierge: Implications for Practice

The use of metaphor can help us to review and re-define clinical practice (McAllister 1995: 397). The language of the gatekeeper is one of exclusion. In the United States, the term 'gatekeeper' is used to describe a designated clinical position, acting on behalf of the health fund, whose primary role is to screen out services deemed unnecessary for patients (Carlson 2008). The metaphor of the concierge is provided as a way of envisaging an approach to acute care that epitomises a focus on consumers and an inclusive, responsive approach to service provision. A comparison of the gatekeeper and the concierge provides an opportunity to view a clinical role that is less defensive, more consumer focused and more compatible with the standards guiding mental health nursing practice (Marks 2010).

'The gatekeeper listens to the traveler desperately knocking; but it is dark and the gates must be locked by night fall. On one level the gatekeeper feels for the traveler, but the town is full and this traveler does not know the password' (Les Clefs d'Or 2007).

Intake workers are required to screen and prioritise referrals at a time when first impressions and expectations are being set for service users. The requirement to manage persistent or multiple crisis situations can provoke a retreat to protective responses aimed at deterring or deflecting those representing a threat to the work group. Clinicians come to value colleagues who can divert a referral or avoid an assessment under the perception that almost every phone call, fax or conversation in an acute care team relates to some form of crisis or problem needing to be addressed. Relationships with other agencies also suffer as diagnostic criteria, designed for clinical purposes, come to be employed as mechanisms for excluding individuals from service (MHCA 2005: 196). Consumers trying to access the service perceive barriers and resistance (Hamilton and Manias 2006: 86). Meta-discrimination (Sullivan 1999: 3) occurs when clinicians add to a consumer's stigma through pressured judgment of who is appropriate or worthy of service, and who might be deflected or triaged out (MHCA 2005: 38; Hamilton and Manias 2006: 87).

'The knocking continues, disconcerting the gatekeeper; what does the stranger want? The gatekeeper daren't open the gate to find out. The stranger sounds desperate – better wait for the sheriffs to arrive in the morning' (Les Clefs d'Or 2007). The need to reconcile issues of care and control is an ongoing dilemma for mental health clinicians working in both inpatient and outpatient acute care settings (Sullivan 1999: 42; MHCA 2005: 66; Cutcliffe et al. 2013: 128) and this dilemma is often played out at the point of intake. Clinicians can err towards control-based approaches, at the expense of care provision, when a focus on gatekeeping replaces that of service delivery (SSCMH 2006: 8). An approach that prioritises crisis response over early intervention means that situations often escalate (Mental Health Commission New Zealand Government [MHCNZ] 2001: 12) requiring involvement of police or other emergency services, before intervention occurs (MCHA 2005: 40; Boscarato et al. 2014: 5).

Acute care services can not only become disconnected from other agencies, but also from other components of their own organisations (Carr 2008: 19). Due to the process of compartmentalisation that has occurred in health care over past decades (SSCMH 2006; Mental Health Commission New South Wales [MHCNSW] 2013: 4), many acute care services are now both physically and operationally separate (MHCNZ 2001: 13; SSCMH 2006). In this context, even other components of the same service can come to represent a threat to the work group (Lloyd et al. 2005: 64), allowing the culture of defensiveness and self-preservation to undermine the continuum of care and lead to disjointed responses in crisis situations. Proactive measures are required to support acute care teams in reconstructing their role as part of an integrated network (Boscarato et al. 2014: 5, 8).

'The Gatekeeper is tired and their body weary. The heavy oaken gate is adorned with many wrought iron embellishments and the hinges are rusting; it gets harder and harder to open as the days go by' (Les Clefs d'Or 2007).

If acute care clinicians do not maintain both an individual and collective awareness of the consequences of falling into a gatekeeping role, they risk becoming despondent, disconnected and desensitised. Effective management should acknowledge these issues and provide clinicians with opportunities to reflect on practice in a way that reaffirms a consumer-centred, solution-focused approach to clinical work and challenges unhealthy workplace culture and rhetoric.

The approach of the gatekeeper is a stark contrast to that of the concierge. Picture yourself walking into the foyer of a hotel. The concierge enquires about your journey and wants to know how you are feeling. They/He asks if they/he can do anything to assist, then advises you about the range of services the hotel has to offer and the places that may be of interest and relevance in the surrounding area.

> The concierge provides a demeanour of calm reassurance and maintains composure ... He/she is flexible, disciplined and persistent and is kind and courteous to all customers and staff alike … Any request will be addressed and if a guest's needs are unable to be met by the concierge, a comprehensive network of contacts means that someone will be able to assist in some way (Les Clefs d'Or 2007).

Mental health nurses account for the majority of acute care intake workers in most services (MHCNZ 2001: 11). Whilst the comparison between mental health intake worker and concierge may appear idealised, greater appreciation might be gained if we reflect on nursing's tradition of holistic consumer care, and the value it places on interpersonal communication and the therapeutic use of self (Peplau 1992: 13). The Australian mental health nursing standards prescribe professionalism, respect, ethical service delivery, collaboration, individualised care planning and integration (Marks 2010). This set of humanistic perspectives on our work with consumers allows us to share the title of 'the caring professions' with our allied health colleagues.

'The well trained concierge knows that the key to good service involves establishing a professional persona through the development of a system of mutually beneficial interpersonal and interagency alliances' (Les Clefs d'Or 2007).

The cultivation of inter-departmental and inter-agency relationships promotes collaboration in care and helps mitigate the stress that can arise when agencies feel they are working in isolation or, worse still, in opposition (Watson 1977; Sharrock and Happell 2000: 24). Only a small percentage of people with mental health problems attend public mental health services for treatment, with the vast majority being serviced by primary care providers in the community (AIHW 2011). In acute care mental health settings, mutually beneficial alliances should involve inter-agency liaison systems that are truly representative of, and supported by, the workplace.

'The good concierge is valued and supported. He/she is continually given tangible support and rewarded by a management that acknowledges the importance of the role' (Les Clefs d'Or 2007).

Just like the concierge, acute care workers need support in maintaining a professional, consumer-focused approach to service provision. The same principles that should govern consumer care such as supportiveness, collaboration and empowerment, also relate to staff care. Professional development programs for acute care staff should place a greater emphasis on interpersonal aspects of practice, clinical skills development and therapeutic interventions (Boscarato et al. 2014: 8) instead of focusing predominantly on risk management processes, accountability measures and administrative requirements (Drake et al. 2001: 180; Calvert and Palmer 2003: 37). Administratively focused meetings are no substitute for meaningful clinical forums that encourage robust discussion and a positive work place culture (Meehan and Boateng 1997: 123). Protected time should be set aside for mechanisms that facilitate reflective practice so that clinicians have adequate opportunity to explore the interpersonal aspects of their work and professional development (Sherwood et al. 2005: 3). Clinical supervision can help foster a culture of support, greater understanding, compassion and empathy towards consumers (Cleary and Freeman 2006: 985). Clinical supervision has also been shown to increase staff resilience (Proctor 1986; Koivu 2013: 1) and encourage critical thinking about practice (Mantzoukas and Jasper 2004: 926). Despite supervision being mandated for authorised mental health practitioners, however, many acute care clinicians remain wary of and disengaged from this important activity.

'To be accepted into the Clef d'Or is a significant mark of recognition and respect for a concierge. It is a reflection of the high esteem in which a good concierge is held by their colleagues' (Les Clefs d'Or 2007).

Acute care clinicians need to acknowledge their part in determining the future direction of their role. It might be wise to reflect on the advice given to consumers about reviewing unhealthy patterns of behaviour, questioning motives and goals, and exploring actions to facilitate personal growth. Acute care work can be a stimulating and rewarding field of mental health nursing requiring highly developed skills, (Fraser 2005: 32; Bee et al. 2008: 448) but many acute care nurses and their colleagues may have been working in gatekeeper mode for too long. Even the most resilient individuals constantly exposed to the negative aspects of the gatekeeper culture, reinforced by mounting non-clinical pressures and with limited support, risk becoming burnt out and cynical. Acute care workers are the public face of the mental health system and need to be supported to maintain their capacity for therapeutic engagement (Bee et al. 2008: 449; Boscarato et al. 2014: 8). There are significant implications for the service and for those it serves when clinicians start to lose hope, adopt defensive practices, and struggle to develop and maintain alliances (MHCA 2005: 67). After all, hope and alliance are key factors determining positive outcomes in mental health care (Seligman 1995: 968; Lambert and Barley 2001: 357).

Conclusion

Acute care teams are comprised of clinicians who choose to work with people in distress. In addition to the emotional labour of their clinical role, they are subject to a range of non-clinical pressures often with limited support and supervision. In many cases, acute care intake workers have come to be seen, and more importantly see themselves, as gatekeepers representing a perpetuation of institutionalised attitudes towards psychiatric care.

The gatekeeper role has evolved at the expense of other important clinical and humanistic aspects of mental health acute care work. The gatekeepers often bear the brunt of frustration and anger directed at a system perceived as struggling to effectively respond to consumer needs.

Whereas the term 'gatekeeper' represents a line of defence against threat, the concierge utilises interpersonal skills to activate a well maintained network of contacts to achieve the best possible outcome for the consumer. The concierge's image is reinforced by accountability, support and validation; a proud representative of an organisation providing a quality product. Whilst the task of regulating service provision is still an aspect of the concierge role, the underpinning philosophy is consumer focused.

Greater emphasis needs to be placed on clinical and therapeutic aspects of mental health acute care work (Fraser 2005: 32; Vic Health 2007). The onus for this change is shared; managers need to explore more practical ways of promoting service integration, ensuring support and encouraging clinical supervision (for acute care clinicians in particular), whilst acute care clinicians need to reclaim their clinical identity and rediscover the ontology of the caring professions.

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I and I live

Diverse, yet one

One race, in humanity

Yes, one human race

I and I live

Diverse identities

Diverse languages

Languages = multicultural lives

Multicultural positive lives, mutually reinforcing ideals

Noble ideals of equality, dignity and freedom for all

I and I live

Sarah Tobhi Motha
Johannesburg, SOUTH AFRICA

On Christmas

All about him
the events gather
though the people no longer do

and neither do they me
and my virgin journey
to harvest past and present sowings

yes darling
it could mean nothing
if you'd just allow it to

the wait could be endured
the accommodation
the immaculate breech combing

the preparation
of a cute ass of burden
and gifts of myrrh for Gomorrah

and the adoration
of the Magi that was extraneous
except for politics, which never is

the Roman feasts
and our wastrel waistlines
the unities, the concretisation

of good things done
and embraces
and all you think of is future focussed crystals

as no cards are written
and you get Christmas phone texts
from people you no longer know as a name

and annually remember you
drunk with very important hi-there's
for which we're all grateful.

Ariel Riveros Pavez
Marrickville, NSW