Review of the Inner City
Community Mental Health Service
2008

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1. THE REVIEW: PURPOSE AND PROCESS

1.1 Review Purpose

In November 2007 Dr Keith Bender, Head of Service of the Inner City Community Mental Health Service (ICCMHS), requested that the Western Australian Centre for Mental Health Policy Research undertake a review of the way in which the service was structured. The review was to inform the future development of the ICCMHS.

The initial focus of the review was to determine the success of an ICCMHS restructure which had established a separate triage/assessment/short term treatment team, known as the Inner City Assessment Team (ICAT). This team was created at the end of 2005 by moving some staff from the existing community teams to the newly formed ICAT and consolidating the remaining staff into a single Continuing Care Team (CCT).

The ICAT was established to:

- Ensure that people discharged from inpatient units were followed up within 5 days;
- Provide a quicker assessment response to referrals of new clients who were considered urgent; and
- Improve the ‘gate-keeping’ function by having assessments undertaken by experienced staff who applied consistent entry criteria and protocols and maintained an up to date knowledge of community resources for on-referral.

The way in which the ICCMHS is now structured and the way it functions can be conceptualised as follows:

Figure 1: ICCMHS Operational Model
After discussion between the ICCMHS Head of Service and the reviewers it was agreed that the creation of the new ICAT would most likely have had an impact on the rest of the ICCMHS. Consequently, the scope of the review was broadened to considering the functioning and structure of the whole service, but with particular consideration to be given to the success of the ICAT and its impact on the CCT.

The review results were to be used, in the first instance, to inform the ICCMHS planning day scheduled for April 2008.

1.2 Review Process

A Steering Committee was formed to guide the review process. As there was a focus on the ICAT it was considered important to include strong representation from that team, together with staff who had a good understanding of the overall functioning of the ICCMHS.

Members of the Steering Committee were chosen by the ICCMHS Executive and comprised:

- Dr Keith Bender (Chair), Head of ICCMHS
- Bernadette Sheehan, Clinical Nurse Specialist
- Phil Carr, Clinical Nurse, ICAT
- Sandal Wilmot, Social Worker, ICAT
- Glenyse Jordan, Social Worker, CCT
- Sandi Nielsen, Administrative Assistant, ICCMHS
- Dr Geoff Smith, Medical Director, WA Centre MH Policy Research
- Theresa Williams, Director, WA Centre MH Policy Research.

At the initial meeting of the Steering Committee in December 2007, the following outline for the review process was presented and endorsed.

![Figure 2: Process for Reviewing the ICCMHS](image-url)
The timelines for undertaking the review were tight as the literature review, consultations, data analysis and identification of key issues were to be completed during January/February, with the results synthesized and ready for presentation at the Staff Workshop on March 26, 2008. This workshop was considered to be an important part of the preparation for the ICCMHS Planning Day scheduled for April 2008.

One consequence of these challenging deadlines is that it was not possible to consult with agencies that work with the ICCMHS, particularly those that refer clients to them. This in no way reflects the importance of feedback from these key stakeholders and the ICCMHS may wish to undertake this consultation in the future to further guide the development of their service.
2. LITERATURE REVIEW

Given the pivotal place of the Community Mental Health Team (CMHT) in providing specialist mental health care to people in the community, there has been surprisingly little research conducted into their role, operation and organisation. Most research conducted on CMHTs has focussed on consumer outcomes. For example, a recent Cochrane Collaboration review concludes that CMHTs provide some treatment benefits when compared with standard non-team community care. However the review offers no guidance as to the most effective way to organize and operate a CMHT (Malone et al, 2007).

2.1 Defining a CMHT

Professor Graham Thornicroft provides a definition of a CMHT that captures its essence:

“A multidisciplinary team of mental health staff which has a lead responsibility for the provision of specialist assessment, treatment and care to a defined population, often defined by geographical catchment area or primary care registration. Such a team will usually provide the full range of functions necessary at the specialist care level, including initial assessment of general adult patients referred from other agencies and teams, consultation to primary care staff on the management of patients, the initial provision of treatment during the onset of a disorder or the early stages of a relapse, and the continuing care of patients with longer term disabilities” (quoted in Malone et al, 2007, p. 2-3).

Thornicroft goes on to note that while specialist teams such as early intervention may supplement the generic teams, the main provision of care for the majority of patients is provided by the CMHT.

2.2 Role and Function of a CMHT

Unlike Community Mental Health Centres in the US….and unlike the newer specialized teams proposed in the UK….CMHTs had, and have, no explicit template. They were not described and then prescribed, but rather evolved by word of mouth as clinicians tried to find ways of dealing with a changing health care system and rising expectations within fixed resources. As a result there have been many blind alleys along the way and enormous local variation in how they are managed, staffed, and function.” (Burns, 2004, p49)
“CMHTs have evolved to meet a broad clinical need with very limited resources. They have suffered by not having a clear description of their functioning and roles....Lacking an identified model and product champion they have often received a poor press – much worse than their performance deserves. They do, however, need clarity of purpose and active management if their potential is to be fully realized and for them to survive in an increasingly accountable health care system”. (Burns, 2004, p71-72)

The UK Department of Health in its *Mental Health Policy Implementation Guide Community Mental Health Teams* (2002) outlines three broad roles for the CMHT:

1. Giving advice on the management of mental health problems by other professionals, particularly advice to primary care and triaging for appropriate referral;
2. Providing treatment and care for time limited disorders which require specialist interventions; and
3. Providing treatment and care for people with more complex and enduring needs.

The Guide goes on to detail specific functions which provide a comprehensive checklist against which a service could review what it does (see Appendix 1). A recent Irish strategic plan for mental health also provides a detailed list of functions and operational guidelines for a CMHT (see Appendix 2).

### 2.3 Organisation and Operation of CMHTs

In 1992/93 the Sainsbury Centre for Mental Health undertook a survey of all CMHTs across England to describe their organisation and operation (Onyett et al., 1994). Although the survey is now 15 years old it has not since been replicated in the UK or Australia, so continues to provide a unique insight into a wide range of operational issues. The following key themes and trends in CMHTs emerged from the survey:

1. There has been a shift to working with people with severe and long-term mental health problems;
2. A greater range of services is being provided including psycho-social interventions, out of hours access, work opportunities and practical help with everyday problems and activities of daily living, however the availability of 24 hour crisis services remained limited;
3. Teams are becoming congested with referrals of people who don’t have severe, long-term mental illness so there is a need for open but targeted services i.e. have an open referral policy but then gate-keep to ensure the defined client group is accepted;
4. There is a need for stronger external and internal team management with a shift toward formal teams with managers and coordinators; and
5. User participation is poor but getting better.

Apart from the Sainsbury survey described above, there are a limited number of publications in the academic literature on the structure and operation of a CMHT. One of the few available articles is by Strathdee (1995) which outlines issues to consider in managing a CMHT. She notes that most CMHTs are generic and provide care to cover a broad range of client needs including new referrals, those requiring acute care and also those with a continuing serious mental illness. Various organisational approaches to managing this diverse client group have been tried including:
- A separate rehabilitation service with assertive outreach;
- Appointing specialist case managers or rehabilitation experts within the generic team where they have dual membership of both their generic sector team and a district-wide rehabilitation service; and
- Dividing the total pool of staff resource to form two sector teams, one providing acute care while the other provides case management and specialist rehabilitation services.

Strathdee comments that whatever the arrangement the caseload must be realistic, with assertive outreach having a caseload of 1:10 and extending to 1:30-40 where there has been a comprehensive assessment, well-developed care plans, stability, crisis arrangements in place and good support from community agencies.

A more recent paper examines barriers to effectiveness and the attributes of an effective CMHT (Singh, 2000).

### Barriers to effectiveness

**Structural**
- Inadequate resources
- Inter-professional differences, rivalries and power differentials
- Unclear lines of management
- Poor inter-agency liaison

**Functional**
- Resistance to change
- Hierarchical v. horizontal decision-making processes
- Failure to target services
- Poor gate keeping
- Failure to prioritise response
- Lack of throughput: failure to discharge stable cases and reluctance to take on complex, difficult to engage patients
- Communication problems
- Ideological commitment to models of care
- Staff burn-out: worries about blame-culture, management pressures

### Attributes of an effective team

**Principles**
- Local and accessible
- Comprehensive
- Effective, efficient and responsive

**Structure**
- Adequately resourced
- Genuinely multi-disciplinary
- Explicit work plans, objectives, review and monitoring systems
- Comprehensive database
- Consumer orientated
- Culturally appropriate

**Functions**
- Meets populations needs, including special needs
- Ensures good practice and use of effective interventions
- Meets legal requirements
- Assesses and manages risks
- Good inter-agency liaison

**Coordination of functions**
- Well led
- Adequate knowledge of local resources
- Proactive in a changing environment
- Explicit management structure and accountability procedures
- Maintains staff morale, professional development and team cohesion
- Evaluates and audits processes and outcomes


**Figure 3:** Effective Operation of a CMHT
2.4 Managing the Boundary

A recent UK study reports enormous variability as to whom GPs refer and whom CMHTs accept. While there was little controversy over referring and accepting people with psychotic disorders, mania, severe depression and phobias, there was a substantial ‘grey area’ comprising acute stress reactions, mild depressive disorder, adjustment disorder, personality disorder, anxiety and panic disorder (Walker et al, 2005).

A study of how one CMHT in the UK managed the boundary provides interesting insights, with a particular theme being “We have to protect ourselves from referral pressures by defining clear points of access” (King, 2001). However, it was not as straightforward in practice as comments from staff show:

“We started using an ICD9 diagnosis definition of severe mental illness. But now I think there is a grey area around severe mental illness. You’re really looking at people with chronic recurrent illness and complex needs, so there’s lots of other factors involved”. (King, 2001, p81)

This lack of consensus about access to CHMTs has been noted in Victoria, where the Auditor General’s Report on Mental Health Services for People in Crisis (2002) indicated a need for improved and more consistent service entry processes. The response the from Department of Human Services has been to fund the development of a consistent State-wide triage classification system and to release a triage program management circular to guide the development of operational policies within the AMHS. Education and training opportunities for triage staff was an important part of the management circular. In September 2005 the University of Melbourne ratified a new postgraduate cross-disciplinary elective subject entitled Mental Health Triage and Intake Practice.

In May this year the Victorian Government released a consultation paper entitled “Because Mental Health Matters” which includes triage as an area for review but more importantly noted, “The question of who public mental health services are for, and who decides this, warrants serious debate.” (Victorian Government Publishing Service, 2008, p.21).

A recent US study in a large, urban community mental health centre with a low-income population has taken a somewhat different approach to improving access to services. Rather than stringent gatekeeping, the centre developed strategies based on improved processes to manage the flow of referrals to enhance access and reduce waiting times (Williams et al., 2008). By developing a ‘continuous flow’ system designed to match demand and reduce backlogs, the waiting time for a psychiatric appointment was reduced from 13 days to 0 days and the no-show rate dropped from 52% to 18%. Specifically the service:

- Developed an effective access team;
- Tracked data to understand the variable demands on the service;
- Evaluated the current system and set goals, including several team members ‘walking through’ the existing access system from a client’ perspective;
- Eliminated the existing backlog of 20 clients waiting for an evaluation; and
- Providing all new clients with evaluations within 48 hours.
A key comment from the researchers was that
“….all team members at the outset of this project assumed that the agency’s demand exceeded supply; the process of carefully tracking demand and supply revealed that additional resources were not needed. Simply adding new staff without changing the system would not have been successful.” (Williams et al. 2008, p112-13)

2.5 CMHT Management Structures

Strengthening external and internal management structures for CMHTs was identified as a key theme in the Sainsbury survey as far back as the early 1990’s. A recent Irish mental health review (Department of Health and Children, 2006) makes specific recommendations about the governance of CMHTs and proposes the following management structure for mental health services at the local CMHT level.

- **Clinical Leadership**
  This clinical leadership position is responsible for articulating the vision of the team and ensures clinical probity. It is expected this role is be filled by a Consultant Psychiatrist. Clinical accountability for all disciplines must also be explicit within the team.

- **Team Coordination**
  A team coordinator should manage the clinical and administrative functions within the CMHT. Their role is to oversee the management of triage referrals, the waiting lists, organisation of teams meetings, liaison with GPs, primary care professionals and local community agencies. An experienced mental health professional at least equivalent to an assistant director of nursing, should fill this position.

- **Practice Management**
  This position undertakes the administrative functions of the team such as budgeting, auditing, data collection and evaluation, IT and systems management. Financial management skills are a key requirement for the position.

2.6 The New CMHTs – Functional Differentiation

By the 1990’s the standard form of non-hospital mental healthcare in England was the CMHT, which aimed to meet the treatment and support needs of people referred for secondary mental healthcare. Anyone who has worked within a generic CMHT will attest that these needs are manifold – covering the full range of diagnostic categories, a broad spectrum of disability and individuals at very different stages of their illness career (or, in contemporary jargon, their patient journey). Concerns that the generic CMHT cannot effectively meet these very varied demands has led to the elaboration within the mental health policy implementation guide (Department of Health, 2001) of a ‘functionally differentiated’ model of community provision that involves a number of teams or services. These include, in addition to the CMHT, dedicated services for early-onset psychosis, crisis resolution/home treatment and assertive outreach.

(Holloway, F. 2006, p. 293-4)

A recent study of investment in mental health services in the UK shows a significant growth in staffing and expenditure for the ‘new CMHTS’ of early intervention, assertive outreach and crisis resolution services rather than for the conventional CMHTs (Goldberg, 2008).
### Deployment of new staff in England, 2001. CMHTs, Community Mental Health Teams

<table>
<thead>
<tr>
<th>Setting</th>
<th>Doctors</th>
<th>Psychologists</th>
<th>Social Workers</th>
<th>Nurses</th>
<th>Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Units</td>
<td>343</td>
<td>47</td>
<td>-12</td>
<td>-9</td>
<td>13</td>
</tr>
<tr>
<td>Outpatient Units</td>
<td>40</td>
<td>36</td>
<td>0</td>
<td>40</td>
<td>105</td>
</tr>
<tr>
<td>Secure Units (all)</td>
<td>266</td>
<td>10</td>
<td>65</td>
<td>1911</td>
<td>243</td>
</tr>
<tr>
<td>Conventional CMHTs</td>
<td>600</td>
<td>22</td>
<td>-635</td>
<td>-749</td>
<td>131</td>
</tr>
<tr>
<td>New CMHTs</td>
<td>415</td>
<td>171</td>
<td>549</td>
<td>3289</td>
<td>673</td>
</tr>
<tr>
<td>Total (these five only)</td>
<td>1664</td>
<td>286</td>
<td>-33</td>
<td>4482</td>
<td>1165</td>
</tr>
</tbody>
</table>


#### Table 1: Deployment of new staff in England, 2001

### Expenditure on selected mental health services, 2002-2006. All prices uplifted to constant 2005 prices. (Data collected from Mental Health Strategies, National Mental Health Finance Mapping 2003-2005)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis resolution</td>
<td>36.6</td>
<td>297</td>
<td>186.0</td>
</tr>
<tr>
<td>Regional medium secure</td>
<td>88.3</td>
<td>173</td>
<td>169.4</td>
</tr>
<tr>
<td>Community mental health teams</td>
<td>366.2</td>
<td>9</td>
<td>106.4</td>
</tr>
<tr>
<td>Assertive outreach</td>
<td>50.7</td>
<td>70</td>
<td>74.5</td>
</tr>
<tr>
<td>Local low secure services</td>
<td>81.2</td>
<td>78</td>
<td>50.1</td>
</tr>
<tr>
<td>Early intervention</td>
<td>7.5</td>
<td>426</td>
<td>48.6</td>
</tr>
<tr>
<td>Primary care mental health</td>
<td>6.3</td>
<td>251</td>
<td>18.3</td>
</tr>
<tr>
<td>Prison psychiatric services</td>
<td>3.2</td>
<td>215</td>
<td>13.2</td>
</tr>
<tr>
<td>Secure high dependency</td>
<td>57.8</td>
<td>38</td>
<td>4.0</td>
</tr>
<tr>
<td>Residential rehabilitation</td>
<td>142.0</td>
<td>0</td>
<td>-14.7</td>
</tr>
<tr>
<td>Total mental health expenditure</td>
<td>3.38 billion</td>
<td>22</td>
<td>470</td>
</tr>
</tbody>
</table>

* Extra expenditure is the excess expenditure on the service, over what would have been spent had expenditure continued at the rate in 2000


#### Table 2: Expenditure on selected mental health services, UK, 2002 - 2006

In Australia, the National Mental Health Report (2007) now recognizes a range of functionally differentiated community mental health service categories, including mobile acute assessment and treatment and mobile intensive treatment/assertive case management.

Victoria provides the best example of the systematic development of ‘new CMHTs’ in Australia. The adult mental health system has a number of standard service components, which are recognisable across the Area Mental Health Services, despite regional differences in organisation and resourcing (Department of Human Services, 2008). The community components are briefly described below:
- **Crisis Assessment and Treatment Teams**
  Operate 24 hours a day to provide urgent community-based assessment and short-term treatment.

- **Mobile Support and Treatment Teams**
  Intensive long-term assertive outreach teams that operate extended hours, 7 days per week.

- **Continuing Care Teams**
  This is the largest component and provides clinic-based, non-urgent assessment, treatment and continuing care.

- **Primary Mental Health and Early Intervention Teams**
  Consultation/liaison and training for GPs in the management of low & high prevalence disorders and provision of short-term treatment for high prevalence disorders.

- **Homeless Outreach Services**
  Work in partnership with other agencies providing services to homeless people with mental illness using an assertive outreach approach.

- **Youth Program – Early Psychosis Services**
  Provides Early Intervention in Psychosis service for people aged 16 to 25.

A recent report from the UK notes that the configuration of these new specialized services and how they work together is not well articulated; nor is there a systematic research programme which has studied the impact of introducing these new services and how they fit with generic CMHTs (Boardman and Parsonage, 2007). This comment applies equally well to Australian services.

### 2.7 Size of Catchment Populations

In reviewing the policy frameworks and guidelines, it is clear that the highly specialised new CMHTs require sizeable catchment populations to be viable. The UK Mental Health Policy Implementation Guide (Department of Health, 2001) specifies the following approximate catchment population sizes for specialized teams:

- Crisis Resolution/Home Treatment Teams: 150,000
- Assertive Outreach Teams: 250,000
- Early Intervention in Psychosis Service: 1 million (comprising 3-4 teams).

Policy guidelines in England note that the population served by a single CMHT may vary from 10,000 to 60,000 depending on the geography and morbidity levels (Department of Health, 2001). A recent mental health review in Ireland proposes that services should be organized in catchment areas for populations of between 250,000 to 400,000, covering two or three local mental health offices (Department of Health and Children, 2006). This configuration would ensure that the full range of services are provided, in particular specialized services which require a larger catchment population. The review also recommends that there be one CMHT per 50,000 population with specialized teams having various catchments population sizes e.g. one recovery and rehabilitation team per 100,000.
2.8 Summary of Key Issues

1. Organisation and Operation of CMHTs
   - While there is limited research on the organisation and operation of CMHTs, a number of jurisdictions have provided significant policy and planning guidance, including specifying role and functions, management structures, staffing mix and numbers and caseloads.

2. Gatekeeping and Access
   - CMHTs have a sense of referral pressure which is managed through gatekeeping.
   - The ‘front end’ function of triage requires a reorientation from ‘gatekeeper’ to linking people with the appropriate service, with perhaps a wider debate on who the public mental health services are for and how boundaries and pathways can be negotiated within the public system and beyond.
   - Certain services, such as Early Intervention in Psychosis, have moved beyond the concept of ‘gatekeeping’ and actively seek out clients in the high-risk groups.
   - There is evidence that actively managing the flow of patients through the assessment process can reduce waiting lists and minimise delay in accessing services.

3. Growth of the ‘New CMHTs’
   - CMHTs have a broad remit and have had difficulty in meeting the variety of demands expected of them. As a result specialised teams/services have been developed, the so-called ‘new CMHTS’, named differently in various jurisdictions but including early psychosis, assertive outreach and crisis resolution/home treatment teams.
   - Specialized services require larger catchment populations to be viable.
   - It is not clear how these new specialized services should be configured and work together, nor is there a systematic research programme which has studied the impact of introducing these new services and how they fit with generic CMHTs.
3. ANALYSIS OF THE DATA

3.1 Population Catchments for Adult Community MH Clinics

The estimated adult population (18 – 65 years) in the ICCMHS catchment area for 2008 was 57,426. As can be seen in Figure 6 below, there is considerable variation in the size of the adult community mental health clinic catchment populations across metropolitan Perth ranging from 24,202 at Clarkson to 147,904 at Bentley.
3.2 Data Analysis Objectives

One of the key aims of the ICCMHS review was to determine whether establishing the ICAT had met its objectives. This translated into:

- Whether urgent referrals and people discharged from inpatient care were being followed up within the pre-determined timeframes, for example, within 5 days post discharge; and
- Whether the number of people admitted for continuing care into the CCT had been reduced.

There were a number of other questions that were considered important in determining how effectively the current structure of the ICCMHS was performing, namely:

- **The Referral Process**: the number and characteristics of the people referred for assessment, which agencies they were being referred from and the people ‘dropping out’ before assessment.
- **The Assessment Process**: the number and characteristics of the people undergoing assessment, those not accepted/on-referred and those taken into short-term treatment by ICAT and the waiting time to assessment/short term treatment.
- **The Continuing Care Process**: the number and characteristics of the people being admitted for ongoing care, those admitted to the Community Recovery Program and those discharged from continuing care.

In relation to the above, the term 'characteristics' refers to both the demographic (e.g. age, gender, postcode) and clinical characteristics (e.g. diagnosis, age at first contact with MHS and ICCMHS). Essentially, the reviewers considered it important to understand how people moved through the system, as shown diagrammatically below, in order to understand the impact of the ICAT on the CCT.

![Diagram of Patient Flow through the ICCMHS](image)

Figure 5: Patient Flow through the ICCMHS
The following sections report on the data in three categories:

- The overall Inner City Community Mental Health Service (ICCMHS);
- The Inner City Assessment Team (ICAT); and
- The Continuing Care Team (CCT) and the Community Recovery Program (CRP).

### 3.3 Overall ICCMHS Activity

The following table shows the overall activity of the ICCMHS by program area. A total of 1,268 people received services from the ICCMHS during 2007, with a total of 21,213 occasions of service (OCS) being delivered.

The differences in the mean OCS across the program areas result from their differing functions. The average OCS in the CCT (mean=20) and the CRP (mean=23) reflect the longer term interventions with clients in these two programs, in contrast to the fewer mean OCS in Triage (mean=1) and ICAT (mean=3) with their focus on short-term assessment and treatment.

<table>
<thead>
<tr>
<th>Unit</th>
<th>No Persons</th>
<th>No. OCS</th>
<th>Mean OCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner City Assessment Team (ICAT)</td>
<td>337</td>
<td>941</td>
<td>3</td>
</tr>
<tr>
<td>Inner City Community Mental Health Service (CCT)</td>
<td>728</td>
<td>14674</td>
<td>20</td>
</tr>
<tr>
<td>Inner City Acute Recovery Program (CRP)</td>
<td>201</td>
<td>4642</td>
<td>23</td>
</tr>
<tr>
<td>Inner City Adult Triage</td>
<td>884</td>
<td>922</td>
<td>1</td>
</tr>
<tr>
<td>Inner City Discharge Follow Up</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Inner City Adult Referrals</td>
<td>17</td>
<td>31</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total Inner City</strong></td>
<td><strong>1268</strong></td>
<td><strong>21213</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

Source: Mental Health Information Service

Note: The same person may have attended more than one unit/program in the same year, so totals across all units will result in double counting.

**Table 3:** Number of persons treated and occasions of service (OCS) delivered by program in the ICCMHS in 2007

Table 4 indicates that of the 1,268 people who received a service at ICCMHS during 2007, the largest diagnostic group were those with schizophrenia, paranoia and acute psychotic disorder (n=784), followed by mood disorders (n=375).

Activity in the ICCMHS broadly reflects this, with 60% of occasions of service for people with schizophrenia, paranoia and acute psychotic disorder and 21% for mood disorders.

The average OCS (mean=16) for a person in the diagnostic category of schizophrenia, paranoia and acute psychotic disorder was higher than for people with a mood disorder (mean=12).
### Diagnosis Type

<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>Gender</th>
<th></th>
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<th></th>
<th></th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Persons</td>
<td>OCS</td>
<td>Persons</td>
<td>OCS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic Disorders</td>
<td>28</td>
<td>181</td>
<td>18</td>
<td>300</td>
<td>46</td>
<td>481 2.27%</td>
</tr>
<tr>
<td>Substance Abuse Disorders</td>
<td>67</td>
<td>373</td>
<td>41</td>
<td>283</td>
<td>108</td>
<td>656 3.09%</td>
</tr>
<tr>
<td>Schizophrenia, Paranoia and Acute Psychotic Disorders</td>
<td>556</td>
<td>9022</td>
<td>228</td>
<td>3617</td>
<td>784</td>
<td>12639 59.58%</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>195</td>
<td>2298</td>
<td>180</td>
<td>2232</td>
<td>375</td>
<td>4530 21.35%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>45</td>
<td>478</td>
<td>35</td>
<td>349</td>
<td>80</td>
<td>827 3.90%</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorders</td>
<td>6</td>
<td>39</td>
<td>3</td>
<td>17</td>
<td>9</td>
<td>56 0.27%</td>
</tr>
<tr>
<td>Stress and Adjustment Disorders</td>
<td>77</td>
<td>204</td>
<td>52</td>
<td>208</td>
<td>129</td>
<td>412 1.94%</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>6 0.03%</td>
</tr>
<tr>
<td>Behavioural Syndromes</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 0.00%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>41</td>
<td>190</td>
<td>52</td>
<td>812</td>
<td>93</td>
<td>1002 4.72%</td>
</tr>
<tr>
<td>Sexual Disorders</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>17 0.08%</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>6 0.03%</td>
</tr>
<tr>
<td>Psychological Development Disorders</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2 0.01%</td>
</tr>
<tr>
<td>Childhood &amp; Adolescence Disorders</td>
<td>5</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>8 0.04%</td>
</tr>
<tr>
<td>Supplementary Codes- Mental Health</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>23</td>
<td>2</td>
<td>23 0.11%</td>
</tr>
<tr>
<td>Unspecified Mental Health Condition</td>
<td>186</td>
<td>282</td>
<td>135</td>
<td>213</td>
<td>321</td>
<td>495 2.33%</td>
</tr>
<tr>
<td>Check Diagnosis</td>
<td>3</td>
<td>50</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>53 0.25%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>775</td>
<td>13,138</td>
<td>493</td>
<td>8,075</td>
<td>1,268</td>
<td>21,213 100.00%</td>
</tr>
</tbody>
</table>

Source: Mental Health Information System

Note: Totals will not add up because the same person can be in more than two units in the same year. Therefore they are only counted once.

**Table 4:** Number of known persons treated and occasions of service (OCS) delivered in the ICCMHS during 2007 by type of diagnosis

Table 5 shows that the average age of clients in the ICAT (38 years) was less than the average age of those in the CCT (42 years) and the CRP (43 years) in each of the three programs (ICAT, CCT, CRP) the men, on average, were younger than the women clients of the ICCMHS.

### Gender

<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>Male</th>
<th>Female</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>Inner City Assessment Team (ICAT)</td>
<td>37</td>
<td>18</td>
<td>77</td>
</tr>
<tr>
<td>Inner City Community Mental Health Service (CCT)</td>
<td>41</td>
<td>18</td>
<td>72</td>
</tr>
<tr>
<td>Inner City Acute Recovery Program (CRP)</td>
<td>42</td>
<td>19</td>
<td>81</td>
</tr>
</tbody>
</table>

Source: Mental Health Information Service

**Table 5:** Average age at contact with the ICAT, CCT and CRP by gender in the ICCMHS in 2007
When the age distribution across the three programs is examined as a percentage (Figure 6) it shows a broadly similar pattern across the programs overall but with ICAT clients being younger. ICAT has a higher percentage of younger clients up to the age of 40 and a lower percentage of older clients aged 50 years onwards when compared with CCT or CRP.

![Age Distribution Chart](chart.png)

Source: Mental Health Information Service

Figure 6: Age distribution of persons expressed as percentage attending ICAT, CCT and CRP programs in the ICCMHS in 2007

### 3.4 Inner City Assessment Team (ICAT)

There were a number of data issues relating to ICAT which limited the capacity of the reviewers to evaluate the activity of that team and its impact on the CCT.

The ICAT team estimate that approximately 20 people per week are referred to the ICCMHS for triage/assessment/short term treatment. It would be expected that approximately 1,000 people would be recorded in the ICAT plus Triage programs for 2007. However, many of the same people recorded in the Triage program (n=684) would be on-referred to ICAT (n=337) and consequently, as they are technically entering a new program, they would be counted again. As a result, there could be as few as 347 clients (i.e. 684 Triage clients – 337 ICAT clients) recorded in PSOLIS. It appears that there has been significant under reporting of activity in the ICAT/Triage programs.

When discussing this data difficulty with staff the following issues emerged:

- Many Triage contacts are not recorded on PSOLIS;
- There is a reluctance to record triage contacts on PSOLIS as it is overly complex and time consuming;
There is no routine, consistent recording of information at the point of triage such as who refers, the presenting problem, whether the client is referred on to another agency, and which agency this is;

Brief contacts with triage staff, such as phone calls are often recorded in a ‘red book’, but this is not routinely recorded. If recorded there are no routine categories of information, nor is the data in its current form readily accessible for analysis;

‘Walk-ins’ are not recorded separately so there is no way to determine the level of this activity and the reason for the client making contact with the service. During the review the ICCMHS decided to record this data, but it was not collected for a sufficiently long period for the review to make use of it;

As clients can have three contacts before they have to be formally admitted to the service, this permits non-recording in PSOLIS; and

After clients are formally admitted to the ICCMHS they have to receive NOCC assessments and this is seen as an addition to the staff work load and acts as a disincentive to admit and hence record the activity.

Consequently, it was not possible to:

Understand the characteristics of referrals to the ICAT (who refers, the presenting problem, on-referrals to other agencies) or whether access to ICCMHS had improved (waiting times for triage/assessment/short term treatment) as this data is not routinely collected, nor

Determine whether the ICAT had reduced the workload of the CCT through effective gate keeping as;

- some client contact is not recorded by ICAT so it could not be compared with any confidence to activity data from the pre ICAT period; and
- there was no certainty that recording of activity in the pre and post ICAT periods had been consistent.

3.5 The Continuing Care Team (CCT) and Community Recovery Program (CRP)

The CRP operates in many ways as a specialized sub-program of the CCT, by almost exclusively accepting referrals from the CCT and primarily providing a centre based group rehabilitation program for clients of the CCT who are referred for specific interventions. While clients are receiving rehabilitation services in the CRP, their case management and overall clinical responsibility remains with the clinical staff in the CCT.

Data from the CCT and CRP is more effectively captured than in the ICAT as the clients are in the service for a longer term. Consequently, it was possible to be more confident about the accuracy of data recorded by these two program areas.

Table 5 illustrates that during 2007 the CCT treated 728 people, largely comprising those whose diagnosis was within the category of schizophrenia, paranoia or acute psychotic disorder (55%) or mood disorders (24%). Most of the occasions of service in the CCT relate to clients with schizophrenia and related disorders (66.6%), followed by those with mood disorders (18.6%). The average OCS (mean=24) for a person in the diagnostic category of schizophrenia, paranoia and acute psychotic disorder was higher than for people with a mood disorder (mean=15).
### Table 5: Number of persons treated and occasions of service (OCS) by diagnosis in the Continuing Care Team (CCT) of the ICCMHS in 2007

<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>No. persons</th>
<th>% persons</th>
<th>OCS</th>
<th>OCS %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic Disorders</td>
<td>19</td>
<td>2.61%</td>
<td>334</td>
<td>2.30%</td>
</tr>
<tr>
<td>Substance Abuse Disorders</td>
<td>19</td>
<td>2.61%</td>
<td>516</td>
<td>3.50%</td>
</tr>
<tr>
<td>Schizophrenia, Paranoia &amp; Acute Psychotic Disorders</td>
<td>402</td>
<td>55.22%</td>
<td>9,769</td>
<td>66.60%</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>178</td>
<td>24.45%</td>
<td>2,735</td>
<td>18.60%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>30</td>
<td>4.12%</td>
<td>342</td>
<td>2.30%</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorders</td>
<td>6</td>
<td>0.82%</td>
<td>36</td>
<td>0.30%</td>
</tr>
<tr>
<td>Stress &amp; Adjustment Disorders</td>
<td>15</td>
<td>2.06%</td>
<td>140</td>
<td>1.00%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>39</td>
<td>5.36%</td>
<td>696</td>
<td>4.70%</td>
</tr>
<tr>
<td>Other Mental Health Disorders</td>
<td>20</td>
<td>2.75%</td>
<td>106</td>
<td>0.70%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>728</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>14,674</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

Source: Mental Health Information Service

Table 5 shows that in 2007 the CRP treated 201 people, largely comprising those with a diagnostic type of schizophrenia, paranoia or acute psychotic disorder (40%) or mood disorder (27%).

Most of the occasions of service in the CRP relate to clients with schizophrenia and related disorders (46%), followed by those with mood disorders (35%). However, the average OCS (mean=26) for a person in the diagnostic category of a mood disorder was higher than for people with schizophrenia, paranoia and acute psychotic disorder (mean=30).

### Table 6: Number of persons treated and occasions of service (OCS) by diagnosis in the Community Recovery Program (CRP) of the ICCMHS in 2007

<table>
<thead>
<tr>
<th>Diagnosis Type</th>
<th>No persons</th>
<th>% persons</th>
<th>OCS</th>
<th>OCS %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic Disorders</td>
<td>5</td>
<td>2.49%</td>
<td>95</td>
<td>2.00%</td>
</tr>
<tr>
<td>Substance Abuse Disorders</td>
<td>3</td>
<td>1.49%</td>
<td>7</td>
<td>0.20%</td>
</tr>
<tr>
<td>Schizophrenia, Paranoia &amp; Acute Psychotic Disorders</td>
<td>81</td>
<td>40.30%</td>
<td>2,144</td>
<td>46.20%</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>55</td>
<td>27.36%</td>
<td>1,636</td>
<td>35.20%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>14</td>
<td>6.97%</td>
<td>367</td>
<td>7.90%</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorders</td>
<td>2</td>
<td>1.00%</td>
<td>19</td>
<td>0.40%</td>
</tr>
<tr>
<td>Stress &amp; Adjustment Disorders</td>
<td>6</td>
<td>2.98%</td>
<td>86</td>
<td>1.90%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>11</td>
<td>5.47%</td>
<td>253</td>
<td>5.50%</td>
</tr>
<tr>
<td>Other Mental Health Disorders</td>
<td>24</td>
<td>11.94%</td>
<td>35</td>
<td>0.70%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>201</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>4,642</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

Source: Mental Health Information Service

Table 6 shows that in 2007 the CRP treated 201 people, largely comprising those with a diagnostic type of schizophrenia, paranoia or acute psychotic disorder (40%) or mood disorder (27%).

Most of the occasions of service in the CRP relate to clients with schizophrenia and related disorders (46%), followed by those with mood disorders (35%). However, the average OCS (mean=26) for a person in the diagnostic category of a mood disorder was higher than for people with schizophrenia, paranoia and acute psychotic disorder (mean=30).

Figure 7 shows that the CCT and the CRP broadly mirror each other when comparing client diagnostic categories and occasions of service for each diagnostic group. However, the CRP does treat a slightly higher percentage of people with anxiety and mood disorders and slightly less with schizophrenia, paranoia and acute psychotic disorders than the CCT.
Figure 7: Persons treated and occasions of service by diagnosis expressed as a percentage in the CCT and CRP of the ICCMHS in 2007

Figure 8 shows the number of years clients of the CCT and CRP have been in contact with public mental health services in Western Australia. Overall, both the CCT and CRP have a high percentage of clients who have been in contact with mental health services for a number of years, with 79% (CCT) and 77% (CRP) longer than 5 years, 60% (CCT) and 57% (CRP) longer than 10 years and 32% (CCT) and 30% (CRP) for over 20 years.

Figure 8: Persons attending CCT and CRP in 2007 by years since first contact with Mental Health Services expressed as a percentage

During 2007 the CCT treated 728 people, of whom 143 were discharged from ICCMHS. Figure 9 shows the discharge destination for the 143 people expressed as a percentage. The highest group of people leaving the CCT in 2007 were those who moved out of the area (39%) followed by those who stopped attending the ICCMHS (27%).
### Figure 9: Discharge destinations for persons exiting the Continuing Care Team (CCT) in 2007

- **Moved out of Area**: 39%
- **Stopped Attendance**: 27%
- **Treatment Completed**: 13%
- **Other CMHS**: 3%
- **GP**: 6%
- **Died**: 6%
- **Self/Home**: 2%
- **MhIs Admin Closure**: 1%
- **One-off Assessment**: 1%
- **Interstate CMHS**: 1%
- **Mhis Admin Closure**: 1%

Source: Mental Health Information Service
3.6 Summary

1. ICCMHS Overall
   - The estimated catchment population of the ICCMHS is 57,426. It is similar in size to Subiaco Clinic (58,323) and Morley Clinic (52,775) and as such is one of the smaller community mental health clinics in the NMAHS.
   - During 2007 a total of 1,268 people were recorded as receiving 21,213 OCS.
   - The largest diagnostic groups were those with schizophrenia, paranoia and acute psychotic disorder (n=784), followed by mood disorders (n=375).
   - Over 80% of the activity of the ICCMHS is directed towards people with schizophrenia, paranoia and acute psychotic disorder (OCS=60%) and mood disorders (OCS=21%).
   - On average, clients in the ICAT were younger (38 years) than those in the CCT (42 years) and the CRP (43 years). The age distribution across the three programs shows a broadly similar pattern but with ICAT clients being younger.

2. ICAT
   - The inadequacy of the data collected in ICAT mean it is not possible to describe the characteristics of the clients, whether waiting times for assessment have been reduced or whether the team has reduced the number of clients referred to the CCT.

3. CCT & CRP
   - In 2007 the CCT treated 728 people (OCS=14,674) and the CRP treated 201 people (OCS=4,642).
   - The largest group treated in both the CCT and CRP were those with a diagnosis of schizophrenia, paranoia or acute psychotic disorder (55% CCT, 40% CRP), followed by mood disorder (24% CCT, 27% CRP).
   - The CRP treats a slightly higher percentage of people with anxiety and mood disorders and slightly less with schizophrenia, paranoia and acute psychotic disorders than the CCT.
   - Both the CCT and CRP have a high percentage of clients who have been in contact with mental health services for a number of years, with approximately a third of clients in both programs having their first contact over 20 years ago.
   - The CCT discharged 20% (n=143) of their clients during 2007, with the highest discharge destination being described as ‘moved out of area’ (39%), followed by those who stopped attending (27%).
4. CONSULTATION WITHIN ICCMHS

4.1 Staff Consultation

Semi-structured interviews were conducted individually with 17 staff members selected to ensure coverage of professional affiliation, clinic programs and length of tenure at ICCMHS. The distribution was as follows:

<table>
<thead>
<tr>
<th>ICAT</th>
<th>CCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 x Mental Health Nurses</td>
<td>3 x Social Workers</td>
</tr>
<tr>
<td>1 x Social Worker</td>
<td>1 x Occupational Therapist</td>
</tr>
<tr>
<td></td>
<td>1 x Mental Health Nurse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CRP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 x Occupational Therapists</td>
<td>1 x Clinical Psychologist</td>
</tr>
<tr>
<td>1 x Mental Health Nurse</td>
<td>3 x Medical</td>
</tr>
<tr>
<td></td>
<td>2 x Administration</td>
</tr>
</tbody>
</table>

The interview questions addressed the following:
- What is positive about ICCMHS?
- What changes could be made?
- What do you think of the separation of ICAT and CCT?
- Why was this structure put in place?
- What have been the benefits?
- Does it work well for clients and their families?
- Does it work well for staff?
- What is your view of the service offered by the Community Recovery Program?
- What would be the best way to organise services in ICCMHS?
- Does anything need urgent attention to make it work better?

The aim of interviewing the staff was to get a range of perspectives on the functioning of the ICAT in particular, but also the other components of the ICCMHS. Staff responses were analysed to identify key themes and significant issues.

4.1.1 Staff Views on the ICCMHS as a Whole

- One of the key strengths of the ICCMHS is the strong sense of positive interpersonal and inter-profession relationships. This is viewed as a key factor in the attraction and retention of staff.
- There was a sense of ‘fragmentation’ between the service programs with little sense of shared purpose and direction.
- There was a sense that the ICCMHS had become ‘stuck’ with a general lack of development of new and innovative services. Staff illustrated this with reference to other community mental health services, which had developed a range of specialised services such as the Early Psychosis services and GP and Aboriginal liaison services.
- Many staff felt under considerable pressure from what they saw as a very high workload.
- There was a concern about the loss of a management structure that had ensued from the split between RPH and ICCMHS.
- The inequality in employment conditions between professional groups working in ICCMHS (e.g. nurses and allied health staff working as case managers in a program) and across the mental health system (e.g. different classifications for nurses in similar roles across the clinics) was raised as a significant problem.
- There was a general sense amongst staff of being overburdened by paperwork and by recording and data demands, including PSOLIS and NOCC.

4.1.2 Staff Views on the Inner City Assessment Team (ICAT)

- There was broad support for the concept of ICAT, which was believed to have reduced the time from referral to assessment and also the number of admissions to ICCMHS.
- There was, however, concern about the staffing of ICAT and in particular:
  - No dedicated Registrar role (shared between 4 medical staff, with no coverage 1 day per week and no home visiting capacity);
  - Consultant shared across programs and also service management;
  - No dedicated Duty Office (role shared between case managers); and
  - Only 3 full-time staff with no coverage for illness or leave.
- There was generally a view that ICCMHS would function better with the previous program model unless the staffing problem could be resolved.
- The staffing level and arrangement were considered to be having a significant impact on ICAT with:
  - Reduced capacity for home assessment;
  - Extensive use of an answering machine when staff are unavailable;
  - Problems in the management of ‘walk-ins’ when staff are on home visits; and
  - Poor communication between registrars and other ICAT staff.
- A number of operational issues were highlighted including:
  - Lack of clarity in decision-making about which clients should be managed in short-term treatment by the ICAT;
  - A significant number of clients did not attend for appointment and considerable time was being spent in ‘chasing up’ clients;
  - There was some duplication of effort between ICAT and CCT in client assessment;
  - Decisions to transfer clients from ICAT to CCT were exclusively medical decisions; and
  - The poor configuration of the physical space at ICCMHS and the lack of access to vehicles were considered by some staff to interfere with the operation of the ICAT.
4.1.3 Staff Views on the Continuing Care Team (CCT)

- The Continuing Care Team was considered by the majority of staff to be too large to operate as a single team. Multidisciplinary teams of around 8 people were seen to be a good size in terms of both functionality and skills mix.

- While the medical staff considered their caseloads to be too large for providing the level and quality of services they desired, case managers, with between 15 and 25 clients, generally felt satisfied with their workload.

- Questions were raised about the ‘case management’ model (i.e. single clinician organising and managing a client’s care) as opposed to ‘case coordination’ (i.e. shared organisation and management of a client’s care by a small team).

- The need for a closer working relationship with both ICAT and CRP was identified by a number of staff as was the need for improved coordination with other agencies such as NGOs, alcohol and drug services, major referral agencies and GPs.

4.1.4 Staff Views on the Community Recovery Program (CRP)

- Staff had widely divergent views about what they believed should be the function of CRP including:
  - It should take on psychotherapeutic and psycho-educational roles and leave the training in living skills to the NGO sector;
  - While some people felt that CRP should be developed as a rehabilitation program separate from CCT, others believed that it should be more closely integrated into CCT;
  - There was a view that CRP should have more of a focus on the development and management of individual care plans and not focus on group programs; and
  - There was a range of views about the relative roles of CRP and the NGO sector, with, at one extreme, a belief that the resources of CRP should be channelled into the treatment of acutely unwell clients and the rehabilitation role left to the NGOs.

- There was a commonly expressed view that CRP was over-resourced and that some of the resources should be used to improve the staffing of ICAT.

- The off-site operation of CRP was considered a problem and it was thought that its relocation to the Murray Street site would raise its visibility and acceptance;

- Restricted access to vehicles was seen as a major inhibitory factor in allowing staff from CRP to work with individuals off-site.

4.1.5 Staff Views on Clinical Psychology

- The role of Clinical Psychology in ICCMHS and its relationship with the other ICCMHS teams was not clear and, in fact, the service was not mentioned spontaneously by any other staff.

- The need for all referrals to be medically assessed rather than being able to be referred directly to Clinical Psychology was questioned.

- It was believed that the new items accessible through the Medical Benefits Scheme had increased the number of referrals to Clinical Psychology, with private psychologists referring on their clients following completion of their compensable sessions.
4.2 Client Views on the ICCMHS

- One of the reviewers [GS] interviewed a number of clients attending the Murray Street Clinic. Clients were asked to comment on the services being provided by the ICCMHS focusing particularly on the following:
  - Ease/timeliness of access to ICCMHS;
  - General degree of satisfaction with the service provided;
  - Particular issues or problems with the service provided; and
  - Continuity of care.

- Clients were satisfied with all the above aspects of services and were generally unaware of the restructuring of ICCMHS services or any changes arising from them.

- The major issue of concern raised by clients was of problems with depot medication amongst those receiving it.

4.3 ICAT Intake and CCT Review Meetings

One of the reviewers [GS] attended an intake meeting with ICAT and a review meeting with CCT to get a clearer picture of their processes and operation. A number of observations were made, namely:

4.3.1 ICAT Intake Meeting

- A number of people referred to ICCMHS, who are currently being assessed by ICAT, could be admitted directly to CCT based upon their clinical and treatment history. This would substantially reduce ICAT's workload.

- There needs to be clearly articulated policies and protocols underpinning decisions to take clients on for short-term treatment by ICAT.

- ICAT's practice, in terms of taking on people for short-term treatment, is overly influenced by the rule that NOCC assessments are mandatory on people after 3 contacts.

- Appointment of a dedicated triage officer would reduce the burden on ICAT staff and assist in more rapid and appropriate allocation of referrals.

4.3.2 CCT Review Meeting

- There was no evidence that case managers were developing individual care plans (ICPs) involving the client, carer where applicable and the multidisciplinary team of providers including NGOs.

- Reviews should be of ICPs and involve key people as outlined above rather than the whole staff of CCT.

- There has been an over-reliance on the model of ‘generic’ case management at the expense of the delivery of protocols of evidence-based interventions by clinical ‘specialists.’

- Coordination of care with other government and non-government agencies is not well developed.
5. CONSULTATION WITH OTHER MENTAL HEALTH SERVICES

During consultation with staff, three other mental health services were mentioned as examples of good practice; Rockingham/Kwinana and Fremantle as being particularly innovative services and Mirrabooka as being similar to ICCMHS in having re-organised into separate assessment and continuing care teams. The reviewers visited these three services to look at their structure and operation.

5.1 Mirrabooka MHS

- The Mirrabooka Assessment and Support Team (MAST), which has a similar function to ICAT, was established in January 2006 with additional funding from the Area MHS to support the establishment of the following positions:
  - Duty Officer;
  - Senior Social Worker;
  - Community Mental Health Nurse L3;
  - Community Mental Health Nurse L2;
  - GP Liaison Officer;
  - Indigenous Mental Health Worker;
  - Psychiatrist; and
  - Medical Officer.

- The evaluation of MAST (2006) provided evidence of a significant reduction in clients admitted to the Continuing Care Team and suggested that there had been a reduction in hospital admission/re-admission rates and length of stay.

- MAST has experienced a number of problems including:
  - Difficulty in the recruitment and retention of a dedicated Duty Officer (MAST has had a series of people on 3 month contracts);
  - Problems with the recruitment of a full-time Medical Officer (MAST has managed intermittently to attract 0.5 FTE Registrar);
  - Retention of experienced staff; and
  - Lack of a Clinical Psychologist attached to the team to assist with the short-term treatment program.

- Mirrabooka has established 2 Continuing Care Teams incorporating Clinical Psychology and rehabilitation, with a Living Skills Program on site.

- The Transitional Program, which is shared by Subiaco, Mirrabooka and Osborne Park Clinics, has had a very positive impact on reducing admissions to the Continuing Care Teams.
5.2 Rockingham/Kwinana MHS

- RKMHS has a full-time, dedicated Duty Officer, L2 Mental Health Nurse, who;
  - Provides a ‘single point of entry’ covering all enquiries and referrals (triage); and
  - Makes contact with all referrals within 24 hours to get further information and to assess the degree of urgency.

- It has 2 Community Teams, each covering a geographically defined catchment area.

- RKMHS also has a number of specialist teams that take on full clinical responsibility for clients:
  - Assertive Community Team;
  - Early Episode Psychosis Team (engages clients for up to 2 years);
  - Living Skills Program; and
  - Intensive Day Therapy program (Day Hospital).

- All services have a close working relationship with the NGOs.

5.3 Fremantle MHS

- The Triage Service:
  - 2 clinicians on duty from 7000 until 2130 (3xL3 and 3xL2 Nurses + 0.5 FTE Social Worker);
  - After-hours role is covered by Nurse Manager; and
  - All referrals go through this ‘single point of entry’.

- There are 3 multidisciplinary teams that provide an integrated community and inpatient service:
  - Each team covers a geographically defined catchment area with responsibility for all clinical care of clients from its catchment area;
  - It provides emergency care until 1500 hrs when the CERT takes over;
  - There is a ‘discrete’ rehabilitation team, but workers are ‘integrated’ within the 3 community teams; and
  - FMHS is about to introduce a similar model (‘separate’ but ‘integrate’) for their Early Episode Psychosis Team.

- There are a number of consultation/liaison services that have an educative role, but also work with the Teams:
  - Accommodation Liaison;
  - Multicultural Liaison;
  - Women at Risk;
  - GP Liaison;
  - Dual Diagnosis; and
  - Aboriginal Liaison.
6. SHAPING THE FUTURE

As outlined earlier, the limitations of the data have made it impossible to prove that the establishment of the current ICAT – CCT structure has reduced the time between referral and assessment or the number of people admitted for continuing care. Notwithstanding, there is a sense amongst staff that it has been effective in meeting these objectives and, as a result, there is general support for a continuation of the model, providing that the ICAT staffing situation can be successfully addressed.

At a workshop with the staff on 26 March 2008, we presented 2 scenarios setting out ‘possible futures’ for the organisation of services within ICCMHS: the first “Making What You’ve Got Work Better” and the second, “Brave New World”. As the titles suggest, the first was not about maintaining the current service arrangement, but improving its operation; while the second proposed a more radical rethink of how services might best be delivered. The scenarios were not meant to be prescriptive, but rather to stimulate thinking about options for the future of ICCMHS as a prelude to the staff planning day, which was to be held on 4 April 2008.

6.1 Improving the Performance of the Current ICAT – CCT Model

While feedback at the workshop was by and large supportive of maintaining ICAT as a separate team, there was a strong sense that staff wanted change in the way that the rest of the service was currently organised and operating.

We have outlined below some of the structural and operational changes that we believe could usefully be considered by ICCMHS if it wants to try to improve its functioning. It needs to be said, however, that a number of the proposed changes such as data collection, evidence-based interventions and the implementation of Individual Care Plans which are discussed below, are not unique to ICCMHS and that CMHTs more generally could benefit from addressing them.

1. Ensuring Proper Resourcing of ICAT

An effective triage system, ideally with a dedicated duty officer position, would significantly reduce the burden on ICAT, increase its responsiveness to referrals and reduce the inappropriate use of an answering machine when staff are out of the office undertaking an assessment. The Rockingham model provides an excellent example of what can be achieved with this arrangement. The duty officer contacts all clients within 24 hours of referral and coordinates their allocation to the appropriate service. Early contact and rapid assessment have been shown to have a significant impact on reducing non-attendance.

Dedicated, full-time medical cover, including the capacity for providing home-assessment, would also significantly enhance the effectiveness of ICAT.

Unlike Mirrabooka, the ICCMHS has had no dedicated resources for the establishment of ICAT and, furthermore, has lost some critical positions in the separation from RPH. We consider that a good case could be made for seeking additional funding for a duty officer and medical officer positions.
2. **Developing Criteria for Admission and Short Term Treatment**

Clear criteria and protocols need to be developed to guide decision-making with regard to which clients should get access to services and which clients should be engaged by ICAT in short term treatment. Some practices seem to be overly influenced by the requirements for undertaking NOCC assessments.

There are a number of clients who, although new to ICCMHS, are not new to psychiatric care. Unless there are exceptional circumstances, these clients could be referred directly to CCT. A reduction in unnecessary assessments and short term treatment would provide ICAT with the capacity to respond more rapidly to referrals and to engage more effectively with referral agencies.

3. **Restructuring the Continuing Care Team**

The CCT was considered by many staff to be too large to function effectively as a ‘single’ multidisciplinary team. Another key issue raised during the consultation was the sense that the ICCMHS had become ‘stuck’ with a general lack of development of new and innovative services. Taken together, they raise the question of whether CCT should be re-structured and, if so, what form any changes should take.

At a minimum, consideration should be given to breaking CCT into 2 multidisciplinary teams based on geographic catchment areas. Alternatively, consideration could be given to maintaining one CCT but in addition establishing a range of specialist services based on the specific needs of the ICCMHS client population, for example, a GP Liaison Service or a Hostel and Homeless Service. The specialist services could be stand-alone as in the Rockingham/Kwinana model or embedded within the CCT as in the Fremantle model.

4. **Clarifying the Role of the Community Recovery Program**

As outlined earlier, there was a very disparate range of views about what functions CRP should be performing. Some people thought that it should take over the total care of clients, including their medical care and case management, while others thought that they should be more closely integrated into the CCT. Essentially, the question is whether ICCMHS has a separate, specialist rehabilitation system or whether it is integrated into the mainstream CCT program.

Opinions were also divided about what services the CRP should be providing, particularly whether it should be skills-based training or psychotherapeutic and psycho-educational inputs.

In Victoria, much of the psychosocial rehabilitation is carried out within the NGO Psychiatric Disability Rehabilitation and Support Service system. Although, some of the functions currently provided by CRP could potentially be provided in the NGO sector, the sector is not as well organised and resourced as in Victoria. Furthermore, a level of clarity needs to be developed within WA about the respective roles and functions of the MHS and NGO sectors in rehabilitation and recovery.
In the meantime, ICCMHS needs to reach a shared position on how it can best meet the psychosocial rehabilitation requirements of its clients. The issues that need resolving are what functions CRP should be providing for clients, how these functions could best be delivered and what should be the relationship between, and respective roles of, CCT and CRP.

5. **Clarifying the Role of Clinical Psychology**

Clinical Psychology currently functions as a separate team within ICCMHS and there is no sense of a shared vision about how the expertise of its members might be used within the broader service. Given the training and expertise of Clinical Psychologists and their growing role in the delivery of evidence-based interventions in the management of people with psychotic illnesses, consideration needs to be given to how they can best contribute to the assessment, short-term treatment, continuing care and rehabilitation of the clients of the ICCMHS.

Consideration also needs to be given to the possibility of clients being referred directly from outside agencies to Clinical Psychology for specialist interventions without medical assessment.

6. **Improving Data Collection**

Although data collection is often seen as onerous, it is critical for understanding what and how much a service is doing, tracking changes over time, understanding resource requirements, planning/designing programs and evaluating services.

The most pressing need is for ICAT to start collecting meaningful data including a record of all referrals, including source and walk-ins, all clients being triaged and all people undergoing short-term treatment. It also needs to accurately record the disposition, including destination, of all clients at each stage, from the initial referral, through triage to assessment need to be collected. CCT needs to also ensure that it accurately records all admissions and discharges including destination.

Before embarking on the above, ICCMHS needs to ensure that its programs are accurately reflected in the data categories currently being used in PSOLIS.

Data collection takes on greater meaning when it is actually being used and ICCMHS needs to start making better use of its data for the purposes outlined above. This can best be achieved by ICCMHS identifying its information requirements and developing a system of regular standardised reporting. With such a system, it would be possible to see that of the 143 people discharged from CCT during 2007, 27% were recorded as simply “stopped attending”. This raises a series of questions, not least of which is whether this is an appropriate clinical outcome.

7. **Strengthening the Management Structure in ICCMHS**

During the consultation process, staff expressed some concern about the loss of an effective management structure following separation of ICCMHS from Royal Perth Hospital. One of the key themes that emerged from the Sainsbury survey of CMHTs in England was the need for a strong and effective management structure (Onyett et al, 1994). Consideration needs to be given to expanding the formal management structure within ICCMHS having regard to the need for a
range of roles including clinical leadership (including disciple specific), service coordination and resource management.

An important task for the expanded management team would be to provide an environment within which staff can develop a sense of shared values, purpose and direction. This will help to reduce the feeling of ‘fragmentation’ described by a number of the staff consulted.

8. Increasing the Availability of Evidence-Based Interventions

Much of the workload within ICCMHS is with people with persistent or recurrent psychotic illnesses and associated disability. As the data show, many of these clients have been in contact with mental health services for extensive periods of time. There are a number of evidence-based interventions that, if applied consistently and systematically over the various stages of these illnesses, can prevent or ameliorate much of the disability and distress (see Appendix 3).

A Cochrane Review of ‘standard’ case management found no measurable benefit and concluded that it was difficult to see how it could be maintained as the cornerstone of community mental health care (Gray et al, 1998). By contrast, Assertive Community Treatment has been found to have considerable benefit, particularly in the management of people who are difficult to engage, non-adherent with treatment, have frequent readmissions and co-morbid substance abuse (Lockwood, 1998).

Consideration needs to be given to reducing reliance on the standard case management model within ICCMHS and investing in the development of the specialised skills in clinical staff that are necessary to build and sustain services based on these evidence-based interventions.

9. Adopting a System of Individual Care Plans

Consideration needs to be given to introducing Individual Care Plans for all clients. The Care Program Approach was adopted in the UK in 1989/90 to ensure that, after assessment, all patients received a care plan that aimed to meet their identified needs (Holloway, 2006).

Individual Care Plans, which can be delivered by a single professional or a multidisciplinary team, often in partnership with other agencies, sets out the role of each party. Clients, their families and the team of people involved in the client’s care are involved in its development and regular review.

The Individual Care Plan approach is particularly pertinent for people with complex care needs requiring input from a range of services. Unlike the standard case management model in which a single clinician is responsible for managing a client’s care, this approach is characterised by shared organisation and management of a client’s care by a team. Care can be ‘coordinated’ by any member of the team, including an NGO.
10. Working in Partnership with Other Agencies

A large proportion of ICCMHS clients have psychotic illnesses, many with complex care needs. Many of these needs, such as housing, education and employment cannot be met by mental health services working in isolation.

The NGO sector is playing a growing role in the provision of psychosocial rehabilitation and support services in WA as in other jurisdictions and there is a pressing need for better coordination of services between the MHS and NGO sectors. Victoria, which has the best developed NGO sector in Australia, has recognised the importance of coordination of client care and has developed an initiative aimed at improving collaboration between the sectors.

ICCMHS clearly has a significant number of clients that it ‘shares’ with NGO providers and it is important that it looks at ways of improving the level of coordination of care. Involvement of all relevant parties in the development and review of Individual Care Plans offers one avenue for this.

GPs and private psychiatrists offer real opportunities for shared care, but the partnerships will need to be built and nourished to turn this into a worthwhile avenue of care. A number of Community Mental Health Services (CMHS) in WA have established GP liaison services, at least in part to foster this development.

ICCMHS, and other CMHS also have a vital role to providing expertise to the alcohol and drug, homelessness and housing and justice sectors where their services are being provided to people with mental health problems. The Fremantle mental health service has recognized this in their development of specialist liaison positions.

11. Improving the Basic Infrastructure

The layout and quality of the ICCMHS building in Murray Street is not up to modern standards and does little to enhance the functionality of the service or the relationships between the teams. The interview rooms, located centrally in the building, are still being shared with the RPH outpatients department.

The facilities at Rockingham provide a sharp contrast. The premises are designed to enhance interaction between the different teams and to promote good functionality in the delivery of client services.

An adequate supply of vehicles is crucial in community mental health services to ensure that staff can actually carry out their jobs. The lack of access to vehicles in ICCMHS limits CRP staff from providing individualised, home-based assessment and psychosocial rehabilitation.
6.2 Rethinking the Service Model

As outlined in the Literature Review section, there has been a national and international trend towards the development of ‘specialist’ community services and, in particular, Early Intervention in Psychosis (EIP), Assertive Community Treatment (ACT) and Crisis Resolution and Home Treatment (CRHT) teams. Victoria provides the best example in the Australian context of the systematic development of the ‘new community mental health services’. Indeed, Victoria has provided a strong lead internationally, particularly in the Early Intervention in Psychosis area. This trend has also been evident in WA with EIP at Bentley and Rockingham/Kwinana and ACT at Rockingham/Kwinana, but the development in this State has been far from uniform and dependent largely on local initiative. The question raised during the staff consultation process was whether ICCMHS should be moving down the specialist community service pathway.

The ‘new’ CMHTs, as they have been labelled, have largely grown up in response to concerns that the generic CMHT had not effectively been able to meet the many and varied demands on the contemporary mental health system. This has led to the development of a ‘functionally differentiated’ model of community mental health service provision. We believe that it is inevitable and desirable that this trend continues within WA.

However, EIP, ACT and CRHT are not services that ICCMHS could realistically look at establishing in isolation. As outlined earlier, the population base required to support the effective development of these services as specialist teams ranges from 150,000 to 250,000. As a result, a number of models of specialist service provision have grown up, such as:

- An ‘integrated’ model which combines specialist services within the generic CMHTs;
- A ‘hub and spoke’ model, a specialist service that provides services to a number of CMHTs; and
- A ‘network’ model, which is similar to hub and spoke but where the specialist team shared by a network of CMHTs.

In terms of EIPs, the outcome research to date supports the specialist team approach as being the most effective.

So, where to from here? There is scope, as outlined above, for the development of specialist functions such as GP Liaison and Hostel and Homeless services within the ICCMHS, but the development of the larger specialist teams would need to be negotiated at the AMHS level.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
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<tr>
<td>AMHS</td>
<td>Area Mental Health Service</td>
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<tr>
<td>CCT</td>
<td>Continuing Care Team</td>
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<tr>
<td>CERT</td>
<td>Community Emergency Response Team</td>
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<tr>
<td>CRHT</td>
<td>Crisis Resolution and Home Treatment</td>
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<tr>
<td>CRP</td>
<td>Community Recovery Program</td>
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<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
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<tr>
<td>EIP</td>
<td>Early Intervention in Psychosis</td>
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<tr>
<td>FMHS</td>
<td>Fremantle Mental Health Service</td>
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<tr>
<td>ICAT</td>
<td>Inner City Assessment Team</td>
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<tr>
<td>ICCMHS</td>
<td>Inner City Community Mental Health Service</td>
</tr>
<tr>
<td>ICD-9</td>
<td>The International Statistical Classification of Diseases and Related Health Problems, Ninth revision</td>
</tr>
<tr>
<td>ICP</td>
<td>Individual Care Plan</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>MAST</td>
<td>Mirrabooka Assessment and Support Team</td>
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<tr>
<td>MHS</td>
<td>Mental Health Service</td>
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<tr>
<td>NMAHS</td>
<td>North Metropolitan Area Health Service</td>
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<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
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<td>NOCC</td>
<td>National Outcomes and Casemix Collection</td>
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<td>OCS</td>
<td>Occasions of Service</td>
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<tr>
<td>PSOLIS</td>
<td>Psychiatric Services On-line Information System</td>
</tr>
<tr>
<td>RKMHS</td>
<td>Rockingham Kwinana Mental Health Service</td>
</tr>
<tr>
<td>RPH</td>
<td>Royal Perth Hospital</td>
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</tbody>
</table>
BIBLIOGRAPHY


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APPENDIX 1: UK Policy Guide to CMHT Key Components

Each of these components must be in place if the service is to operate effectively

- Working with Primary Care
- Assessment
- Social Services Assessment
- Team Approach
- Regular Review
- Interventions to be provided primarily but not exclusively for those with short-term needs
  - Psychological Therapies
- Interventions to be provided primarily but not exclusively for those with severe and enduring illness
  - Physical health care
  - Continuity of care
  - Medication
  - Basics of daily living
  - Help in accessing local opportunities in work and education
  - Support
  - Family and carer support and help
  - Treatment of substance abuse
  - Relapse prevention
- Liaison with Other Parts of the Health System
  - Inpatient care
  - Discharge
  - Liaison with primary health care teams
  - Liaison with other bodies
- Discharge and Transfer Arrangements
  - Discharge from CMHT
  - Routine transfer
  - Emergency transfer
# APPENDIX 2: Functions & General Operational Guidelines CMHTs in Ireland

<table>
<thead>
<tr>
<th>Function</th>
<th>Operation</th>
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<tbody>
<tr>
<td>Liasing with primary care services</td>
<td>Provide support and advice to primary care services regarding management of the large proportion of mental health problems they treat. These consultations may take place in respect of a particular service user, or may occur through a member of the CMHT who is assigned to liaise with primary care providers.</td>
</tr>
<tr>
<td>Processing new referrals</td>
<td>All referrals to the CMHT should be through a single point of entry, clearly identified to primary care services. This function may be assigned to the team coordinator, who will bring each new referral to the regular scheduled CMHT meetings for discussion. In managing new referrals, consideration should be given to making the best use of the resources and specific skills of the team members to avoid prolonged delays for service users in accessing treatment.</td>
</tr>
<tr>
<td>Setting up care plans</td>
<td>The needs of each service user should be discussed jointly by the team, in consultation with users and carers, in order to construct a comprehensive care plan. Care plans should be written and agreed between all parties, and include a timeframe, goals and aims of the user, the strategies and resources to achieve these outcomes, and clear criteria for assessing outcome and user satisfaction.</td>
</tr>
<tr>
<td>Assigning a key worker</td>
<td>Where care of an individual is assigned to more than one of the team members, a ‘key worker’ – a team member who will be known and accessible to the service user and through whom clinical services can be personalised and coordinated – should be identified. The role of key worker can be assigned to any discipline within the team, subject to discussion and agreement.</td>
</tr>
<tr>
<td>Supporting carers</td>
<td>The burden experienced by individuals who provide regular and substantive care to people with severe disorders should be recorded and monitored as part of the overall care plan.</td>
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<tr>
<td>Managing future crises</td>
<td>As part of the formal care plan, it is recommended that the team, in collaboration with the service user, evolve agreed protocols for managing any future mental health crises that may arise.</td>
</tr>
<tr>
<td>Involving service users and carers</td>
<td>A person-centred, recovery-oriented service requires the active participation of service users at each level of service delivery and this should be an intrinsic aspect of CMHT development. The involvement of advocates and carers needs to be facilitated as a matter of priority, as their commitment and involvement with the service user plays a key role in their recovery.</td>
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<tr>
<td>A ‘child-friendly’ approach</td>
<td>The safety and well-being of children whose needs may be compromised by parental illness needs to be carefully monitored. The team should discuss with the user how a child’s unmet needs can be considered. In the event of a high-risk situation developing, the child’s needs must take priority.</td>
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<tr>
<td>Regular team meetings</td>
<td>Regular scheduled meetings of the CMHT are critical to care coordination and team development. The full team routinely discusses assessments, care plans and reviews service capacity. Team meetings serve as a forum for discussing referrals to other specialised services – e.g. early intervention, rehabilitation, forensic services – and for planning and ensuring continuity of care across different teams/programmes.</td>
</tr>
<tr>
<td>Case notes</td>
<td>There should be a single written record for each service user, where entries are made each time a team member has contact with them or with significant others in the course of their recovery.</td>
</tr>
</tbody>
</table>

| Linking with community resources   | A critical function of the team is to maintain integration of the user in their community life factors which promote/inhibit a service user’s capacity to sustain themselves in the community will form part of the care plan. An assigned member of the CMHT will act as an advocate for the user in negotiating practical difficulties with key individuals and agencies where employment or accommodation has been jeopardised by their mental health problems. Teams should keep a resource file of local provisions and opportunities available to service users. |
| Linking with other health services | All CMHTs should have formal links with other health services in their area, particularly with relevant departments in general hospitals. CMHTs should have direct access to medical and radiological services, as part of the comprehensive assessment of specific presentations. This is especially the case for those services which have few links to the general hospital, such as child and adolescent mental health services. |
| Ongoing contact with primary care  | Contact with primary care services should be maintained to inform GPs, or other referral agencies, of the user’s progress in recovery and their discharge from secondary or tertiary services back to the community. |
| Addressing the user’s practical needs | Mental health workers have a role to play in offering direct practical help to service users, particularly those with severe and enduring illness. Help with obtaining benefits, and with budgeting, shopping and child minding may be appropriate in fostering independence and effective integration in their local communities. |
| Hours of operation                 | A fundamental component of the CMHT is to clarify arrangements for provision of a 24-hour multidisciplinary crisis response capacity. |
APPENDIX 3: Evidence-Based Interventions in the Treatment of Psychosis

EVIDENCE-BASED INTERVENTIONS

- Pharmacological Management
- Cognitive Behaviour Therapy
- Cognitive Remediation
- Family Interventions
- Assertive Community Treatment
- Training in Illness Management Skills
- Integrated Treatment for Co-morbid Substance Abuse
- Skills Training ['real life']
- Supported Education
- Supported Employment
- Supported Accommodation

Delivering a Healthy WA