DEVELOPING ADULT COMMUNITY MENTAL HEALTH SERVICES IN WA

System Issues that Emerged during the Inner City Community Mental Health Service Review

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DEVELOPING ADULT COMMUNITY MENTAL HEALTH SERVICES IN WA:
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1. SYSTEM LEVEL ISSUES

As part of the evaluation of ICCMHS, we:

- Examined the structure and functions of the Fremantle, Rockingham and Mirrabooka Adult Mental Health Services;
- Carried out an extensive literature review of community mental health services, including what has been termed the ‘new community teams’; and
- Undertook a detailed analysis of the Victorian mental health system.

During this process, we identified a number of important issues that have relevance for the WA community mental health system and these are outlined below.

1. Entry to Services: Building a more proactive system

As mental health services struggle to keep up with demand and increasing client complexity, entry thresholds have been raised requiring people to meet a higher level of clinical acuity before they can receive services. Western Australia’s public mental health sector is now primarily targeted at people affected by psychotic illnesses; and then often at a late stage when they are presenting in crisis.

Despite the research evidence emerging from the specialist Early Intervention in Psychosis programs demonstrating that the shorter the duration of untreated psychosis, the better the outcome, the average time between the onset of psychosis and entry to treatment has been found to be 2 to 3 years.

As identified in a number of reports [e.g. Not for Service, MHCA/HREOC], people with mental health problems and their families want clear and direct pathways to the right mental health care when and where they need it – whether it be from primary health care, private psychiatry or allied health, drug and alcohol services or public mental health services.

This means creating much more accessible and easy to navigate entry points and a stronger triage capacity – the ‘front door’ of the specialist mental health service system – for people who are unwell.

The triage function has evolved unevenly in the WA mental health system and progressive improvement is needed in order to re-orientate the triage role from ‘gate-keeper’ to one that assists clients ‘early’ to find the most appropriate services based upon their assessed needs.
2. Service Components: Developing standard service components across the CMH sector

During our consultations with Inner City, Mirrabooka, Fremantle and Rockingham Mental Health Services, it became apparent that they not only have unique organisational structures, but also offer unique suites of services. The service components appear to owe much more to the history of local development than to any objective measure of local catchment population/client needs.

A number of senior staff proposed that what WA needed was a more systematic approach to the development of community mental health services, with identified standard service components backed by some form of resource allocation formula. Victoria provides the best example of such an approach with a set of standard service components that are recognisable across all Area Mental Health Services. Victoria has also been very systematic in the introduction of new services, such as the Youth Program - Early Psychoses Services.

The Department of Health in the UK has adopted a similar approach, particularly in relation to the development of its 'new community services' - Early Intervention in Psychosis [EIP], Assertive Outreach Teams [AOT] and Crisis Resolution and Home Treatment [CRHT]. The roles, functions and resource requirements for these new programs, which have been widely disseminated across the UK, are set out in the Mental Health Policy Implementation Guide [2001].

The so-called ‘new CMHTs’ have developed essentially to complement the ‘standard CMHTs’ to ensure that the needs of clients and their families are more effectively met. There is growing evidence to support the effectiveness of specialised services like EIP and AOT in the management of people with psychotic illnesses. The argument is no longer about whether community mental health services should be providing these ‘functions’ but rather about how they can best be organised and how they can best be integrated or coordinated with existing standard CMHTs.

EIP services, for example, can be provided by a separate, stand-alone team [e.g. Rockingham] or integrated into existing community teams [e.g. Fremantle]. Another option that has not been used in WA is the ‘hub-and-spoke’ model in which a separate, stand-alone team services a number of standard CMHTs within an AMHS. To date, the evidence seems to favour the efficacy of the separate, stand-alone team over the integrated service.

The emergence of the ‘new CMHTs’ raises the issue of the current size of WA’s community mental health service catchment areas.

The UK Department of Health has specified the following approximate catchment population sizes for the new specialised teams:
- Crisis Resolution/Home Treatment Teams: 1 team/150,000 persons
- Assertive Outreach Teams: 1 team/250,000 persons
- Early Intervention In Psychosis Services: 1 Service [comprising 3 to 4 Teams] per 1 million persons

As can be seen from the attached map [Attachment 1], there is considerable disparity in the size of the Clinic catchment areas in Perth ranging from ICCMHS with 75,500 to Bentley with 216,000.

If the population benchmarks set out by the DoH [UK] were adopted, Clinics like ICCMHS, Subiaco and Mirrabooka would not have the population to be able to support stand-alone specialist teams. Consideration would need to be given to networking specialist services across a number of catchment areas [hub-and-spoke model] or amalgamating some of the Clinic catchment areas.

A possible model for the amalgamation is outlined below.

\[
\begin{array}{|l|}
\hline
\text{Population} \\
\hline
240,000 \\
223,000 \\
216,000 \\
201,000 \\
199,000 \\
189,000 \\
177,000 \\
124,000 \\
\hline
\end{array}
\]

Larger configuration of the catchment areas, as outlined above, would provide a more viable population base for the planning, development and management of a comprehensive range of inpatient and community-based mental health services. The Area Mental Health Services, which are the basic structures for service planning and delivery in Victoria, have populations of approximately 150,000 to 300,000. Underpinning the Victorian system is a well-developed and transparent resource allocation model.

3. Evidence-based Interventions: Building and sustaining evidence-based interventions in clinical practice

People with persistent or recurrent psychotic illnesses and associated disability make up a large proportion of the current workload of community mental health services in WA and the data show that many of these people have contact with mental health services for extensive periods of time. There are a number of evidence-based interventions [Attachment 2] that, if applied consistently and systematically over the various stages of these illnesses, can prevent or ameliorate much of the disability and distress.
However, apart from pharmacological management, which is recognisably very important, most people actually receive a very limited range of evidence-based interventions because they are not provided in routine mental health settings. Over the years, ‘generic case management’ has taken on a central role in the management of people with persistent or recurrent mental illnesses, largely at the expense of ‘clinical specialisation’ and many staff no longer have the skills required to deliver evidence-based interventions.

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. 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.

Implementing effective interventions in mental health treatment programs is a critical challenge for the field. Consideration needs to be given to reducing reliance on the generic case management model and investing in the development of the specialised skills amongst our multidisciplinary teams that are necessary to build and sustain services that will consistently deliver these evidence-based interventions. The DoH [UK] has recognized that this requires a highly trained workforce and, to this end, has funded a number of large-scale training programs across England.

4. NGO Sector: Expanding capacity

Victoria currently invests around 12% of its mental health budget in the provision of NGO services; primarily in the provision of psychosocial services within the Psychiatric Disability Rehabilitation and Support Services [PDRSS] system. The PDRSS is one of the best organised and most comprehensive psychosocial rehabilitation systems in Australia.

The NGO sector in WA is much less developed and there is clearly considerable scope for further growth. Apart from Rockingham, we found that the community mental health services we consulted did not have any organised or coordinated relationship with NGOs operating in their area. There is, even within current resources, considerable scope for increasing clinical outputs through better coordination of services between the public and NGO sectors.

The NGO sector in WA is clearly already growing rapidly with the establishment of programs such as CSRUs, Community Options and Personal Helpers and Mentors. One important lesson that can be learnt from Victoria is that development of the sector needs to be planned and, as part of this, strategies need to be put in place to foster better coordination between the sectors. Victoria recently introduced a program to improve coordination, part of which involves rationalising the number of NGOs operating in each AMHS area.
The growth of the NGO sector provides a significant opportunity for the refocusing of public mental health services. The clinical workforce in the public sector is made up primarily of people with professional qualifications who require years of tertiary training, are difficult to recruit and retain and are relatively high cost. Some of the functions currently being carried out by health professionals in WA are being performed by paraprofessionals employed in the NGO sector in Victoria. Introduction of a similar policy in WA would allow for a shift in the focus of professional staff to take on greater roles in community training, consultation and liaison, promotion and prevention, assessment and triage, building partnerships and the provision of highly specialised evidence-based interventions.

5. Partnerships: Building responsive public mental health services

With a few notable exceptions, the WA community mental health system has not built strong partnerships with primary care, private mental health [psychiatry and allied health], the NGO sector, housing and employment, welfare sector or alcohol and drug services. Whenever this issue is raised, time constraints and confidentiality are cited as the major barriers.

There are a significant number of clients referred to mental health services that could be managed by the other agencies listed above or by mental health services in collaboration with them. The public mental health sector needs the capacity to provide consultation and capacity-building to these other service sectors, enabling them to draw on its expertise and experience and, when necessary, its resources. The lack of coordination of services has been identified as one of the major problems nationally and internationally – and there are significant social and resource costs associated with it.

6. Individual Care Plans: Coordinating care at the service level

The Care Program Approach was adopted in the UK in 1989/90 following a series of tragedies to ensure that, after assessment, all patients received a care plan that aimed to identify their needs and ensure that they were met.

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 follows on from 4 and 5 above as a means of coordinating care at the service level and addressing the issue of confidentiality in the sharing of client information. It is particularly pertinent for people with complex care needs requiring input from a range of individuals and 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. Consideration needs to be given to introducing the Individual Care Plan approach in WA.

7. Data Collection: Making data collection relevant in clinical practice

During the review of ICCMHS, a number of significant data collection problems emerged, particularly in relation to ‘referral’ and ‘triage’. As we found on wider consultation, these problems were not restricted to ICCMHS. Although PSOLIS has referral and triage modules, many referral and triage contacts were not being recorded electronically but rather entered in hard copy in ‘communication’ books. One reason given was that staff found the current triage module in PSOLIS is overly complex and time consuming to use. By contrast, staff found communication books were a convenient and effective method for sharing information.

Manifestly, there are major problems with the manual recording of data because:

- the system is not capturing client contact information in a form that can be readily shared across the service system;
- activity is being under-reported and this has significant implications for service planning, resourcing, quality and evaluation.

The underlying dynamic appears to be that staff feel ‘burdened’ by the amount of, what they see as, ‘non-clinical’ work and do not see any tangible benefit for their practice in entering data in PSOLIS: in cost-benefit terms, the ‘time’ cost outweighs any apparent benefit. As a result, the data, where it is actually recorded, is often not accurate or complete.

If this is situation is to change, PSOLIS must be seen as useful to clinicians in their everyday practice. This will require simplification of some elements of the system and regular, meaningful reporting. As one Social Worker commented, all systems need to be regularly reviewed in partnership with the people that use them to ensure that they remain relevant and effective. We believe that the time has come to review PSOLIS – in partnership with the clinicians who use it.

8. National Outcomes Casemix Collection: Balancing the real cost of routine outcome measurement

NOCC was introduced into routine clinical practice across Australia in the mid 1990s as part of the National Mental Health Strategy. It is still not well received by the vast majority of clinicians after over a decade of use and adherence to the protocols has been very patchy.

There are two major reasons for this. Firstly, it was never properly resourced and clinicians see it as just an additional demand in their already over-
burdened work schedules. Secondly, the whole concept is flawed from a scientific standpoint and the usefulness of the data is highly questionable. It is not surprising, therefore, that there has, to date, been little output of any note nationally from the whole exercise. There are certainly less resource intensive but effective ways of evaluating system and service outcomes.

There are significant opportunity costs associated with NOCC. We found that it had an undue influence on data recording and clinical decision-making, particularly in relation to short-term treatment and admission.
2. WHAT WOULD A MODERN, EFFECTIVE COMMUNITY MENTAL HEALTH SERVICE LOOK LIKE?

1. Underlying Principles
   - Prevention and Early Intervention
   - Recovery Orientation
   - Social Inclusion
   - Evidence-Based Practice
   - Shared Responsibility

2. Service Elements
   - Proactive approach to identifying clients early.
   - Facilitate clear and direct pathways to mental health care when and where it is needed.
   - Work closely with primary care to enhance their capabilities.
   - Provide an emergency response (24/7) focussing on treating people in the community wherever possible.
   - Provide a range of specialist interventions for:
     ❖ Youth early in the course of their psychosis
     ❖ People who are hard to engage/non-compliant
     ❖ People with persistent and recurrent illness and disability
     ❖ People with co-morbid substance abuse.
   - Introduce routine needs assessment and Individual Care Plans.
   - Provide the full range of evidence-based interventions.
   - Establish joint working relationships between the public and NGO mental health sectors.
   - Establish strong linkages with the social services system [e.g. Justice, Housing, Education, Employment].
   - Integrating community and inpatient services with community services taking a ‘lead’ role.
   - Catchment populations large enough [150,000 to 250,000] to support a full range of services.
   - A systematic approach to providing standard components of community mental health services.
ATTACHMENT 2: 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