Future Directions Workshop: ICAYMHS
10 December 2009

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Outline of Presentation

- Review objectives/scope/process
- Themes from consultations
- Learning from other jurisdictions
- Reflections
- Principles underpinning the review
- Where to from here?
  - Key decision point 1 - Working with the Emergency Services
  - Key decision point 2 – Intervening Early
  - Key decision point 3 – Multiplying Capacity
  - Key decision point 4 – Creating a System
Objective and Scope of the Review

- Objective to determine whether the MH emergency service system is responding effectively to people experiencing a psychiatric crisis – specifically examine:
  - Emergency Departments
  - MHERL
  - CERTs
  - CMHT triage and emergency response

- Scope to include ICAYMHS, Adult, Older Adults

- System approach to the Review
Entry Points and Pathways in the Emergency System

- MHERL
- CMHS
- Inpatient Unit
- CERT
- Emergency Department
What is an Emergency?

An emergency can be defined as:

“... an acute disturbance of thought, mood, behaviour or social relationship that requires an immediate intervention as defined by the patient, family or the community. ... Central to the concept of an emergency are the subjective qualities, the unscheduled nature, lack of prior assessment or adequate planning and resultant uncertainty, severity, urgency and conflict or failure of natural or professional supports all of which contribute to the need for immediate access to a higher level of care.”

Urgent problems:

“... as opposed to emergencies can be thought of as situations that have some or all of these features but where the situation is evolving more slowly, the feared outcome is not imminent and attention can be delayed for a short time.”

Source: APA Taskforce on Psychiatric Emergency Services, 2002
Review Process

1. Establish Reference Group
2. Consult with Stakeholders
3. Visit other Jurisdictions (Victoria & NSW)
4. Review Literature
5. Service Utilisation Data
6. 2 x Workshops
   - Adult & Older Adult
   - ICAYMHS
     - Key Issues
     - Future Options
7. Draft Report
8. Presentation of findings to Reference Group
9. Feedback
10. Final Report
Emergency Services Review Reference Group

Membership:

- Leanne Sultan (Chair)
- Deborah Bridgeford
- Denise Bromwell
- Dr Simon Byrne
- Dr Johann Combrinck
- John Ellis
- Jennifer Hoffman

- Patrick Marwick
- Kate McGivern
- Dr Helen McGowan
- Dr Willem van Wyk
- Dr Geoff Smith
- Theresa Williams
Staff Consultation

**Emergency Departments**
- PLN’s/Consultant Psychiatrists/ED Physicians
  - Swan
  - RPH
  - SCGH
  - Joondalup

**CERTS**
- Swan
- Osborne Park
- Joondalup

**Inpatient Units**
- Graylands
- RPH
- Joondalup

**Patient Flow Coordination**

**CMHTs**
- Service Co-ordinators/Clinical Directors/Nurse Directors
  - Swan
  - Inner City
  - Mirrabooka
  - Joondalup
  - Osborne Park
  - Subiaco

- Staff Forums – open invitation
  - Subiaco/Inner City
  - Swan
  - Joondalup
  - Osborne Park

**Child, Adolescent, Youth**
- Clinical Director, ICAYMHS
- Staff Forum – ICAYMHS, YouthLink
- PMH, Department of Psychiatry
- PMH ACIT

**Older Adult**
- Clinical Director
- Staff Forum – open invitation

**NMAMHS Executive**

**MHERL**

**Hospital @ Home**
Key Themes from Consultations

1. The Emergency Gateway
2. Developing Community Mental Health Services
3. Access to Inpatient Beds
4. System Fragmentation
5. Services for Children and Youth
The Emergency Gateway

1. Gatekeeping
   - The whole system acts to try to prevent people getting in.
   - It’s not easy for consumers to access the right care, in the right service, at the right time.
   - CERTs are doing their own assessments because they can’t trust MHERL.

2. Navigating the system
   - A lot of time is spent navigating the system.
   - There is no clear systematic approach, common policies or protocols across the various services. This extends to EDs which also vary in their response.
   - There is lots of duplication and fragmentation in the new system for referrers, clients, police, EDs and hospitals.

3. ED as a major entry point
   - The system has become incredibly dependent on the ED … as other systems reach capacity, patients drain down to us.
   - The waiting time for beds has improved, but it is still not unusual for people to have to wait here in ED for 24 to 48 hours and sometimes up to 3 days.
   - At worst, ED is unacceptable clinical care … we are often juggling sedation, physical restraint and surveillance.

4. The role of the Police
   - The Police won’t come to assist with a scheduled patient unless there is a bed.
   - The biggest problem is ED to hospital transfer. You can get a bed but then have to wait for 4 to 6 hours to get transportation by the Police.
   - Police see it as their role only to get involved if there is a risk … they want to make sure Health is not using them as a taxi service.
Developing Community Mental Health Services

1. Extend hours of operation
   - We need to be serious about making community services viable 24 hours a day.
   - ED is the only place that after hours has its lights on and presentations there are all about the lack of other community alternatives.
   - Bentley had an after-hours service for a number of years and this reduced admissions.

2. Provide intensive community treatment
   - The future is in intensive home treatment … we know that it works.
   - If community teams had their own intensive home treatment service, they would hang on longer, knowing that there was extra support.
   - Hospital-@Home gave us a taste of what could be done to decrease the burden on ED and beds … the single best initiative in the past 10 years.

3. Embed service elements
   - CERT see themselves as part of the Pod, but should be part of our team.
   - CERTs are currently ‘in’ clinics, but not ‘part’ of them.
   - The centralised system of people coming out to offer their services is not working.

4. Prioritise resources
   - We have lots of ‘just in case’ services – CERTs, weekend clinic staff, PLNs, MHERL – that are fragmented and have huge resources tied up.
   - With the weekend services all 6 clinics have 2 staff on duty each day – that is 24 staff involved. How about rostering staff over larger groupings?
Access to Inpatient Beds

1. Improve access to beds
   - To get people into a bed it is often best to advise them to go to the ED. The hospital gives priority for beds to people in its ED rather than those coming direct from recommendations from the CMHT.
   - Getting a locked bed is difficult. If there are no beds we often take the person direct to Graylands and have to stay to manage the person until a bed becomes available, sometimes up to 12 hours.

2. Strategies to improve access
   - Flow Coordinators have a map of what’s available, but staff still have to do a lot of ringing around. I haven’t seen any improvement on the ground in access to beds. Staff still get very stressed trying to get a bed and you can have 2 or 3 staff on the phone ringing around trying to find a bed.
   - Direct admission to D20 is a good system.
   - There has been an increase in bed availability because of the Flow Coordinators … with the Metro Bed Manager, they have provided greater clarity and transparency across the system about bed availability.

3. Alternative bed types
   - Community assessment and management is the ‘ideal’, with step-up and step-down services needed as an alternative to admission.
   - I would support the PECC type system where we can hold people we are uncertain about for a couple of days … probably only need 1 six bed unit for North Metro and 1 for South.
   - I don’t support the concept of PECC … making mini-wards that are not economic or a proper environment. It is better if they go to proper psychiatric units where there is a full range of services, facilities and staff.
System Fragmentation

1. Improve Continuity of Care
   - Mental Health Services have a ‘pass-the-parcel’ mentality.
   - Community mental health services disengage when people go to hospital, despite it often being a blip on their long-term care pathway.
   - The Clinical Re-design Program has been looking at the role of community teams in the inpatient setting with the aim of reducing fragmentation of patient care.

2. Increase Service Integration
   - We have to make a decision about where we see the system centred – it should be a community-centred system.
   - There are all the component parts, but the hotspots are the intersections between the PLNs, the Assessment Team and CERT.
   - Too many agencies operating as silos. Freo is a good model with everything on the one site.

3. Improve Communication
   - PLNs do not have much of a relationship with the Clinics. We get no feedback on people referred to them.
   - The use of PSOLIS is patchy, but double entry onto PSOLIS and into the case-notes is a problem.
   - The CERTs are often having to set up their own files as risk assessments and care plans are not often entered in PSOLIS. If you don’t have sufficient information, you have to ring around to get copies of discharge summaries.
Services for Children

- CAMHS has limited ability to respond to day-time emergencies. There aren’t many emergencies for under 8’s, occasional for 11 to 13’s, but mainly 15 to 18 year olds.

- ED is the only direct point of access for consumers.

- Triage tasked to make contact with priority clients within 48 hours and generally not able to make face-to-face contact, only telephone, and this feels inadequate.

- Currently triage find it hard to respond to the level of need. Often refer to the ED. Have 60+ on their wait list while gathering information and doing an assessment.

- CAMHS are not high users of MHERL and CERTs so we tend to fall off their radar.

- CAMHS don’t seem to understand the nature of the work in ED. Sometimes we get a standardised letter from them 2 to 3 weeks later saying that the person has not been accepted.

- Everything funnels through PMH. It is difficult to get clients into CAMHS and sometimes the consultant psychiatrist referral is not accepted. It might get through triage but then is rejected by the team.

- PMH have lost 4 psychiatrists this year because of the onerous nature of the on-call. We recently tried to get the CAMHS psychiatrists to participate in the on-call roster and do a couple of weekends every few months but we haven’t had a response.
Services for Youth

- YouthLink has a limited ability to respond to emergencies and we try to negotiate with the adult system. But there is no clear systematic approach across the adult program. This is the same for the EDs.

- The day time emergency response from the Clinics varies. A lot of time is spent navigating the system.

- Emergency plans on PSOLIS work well.

- Bentley Adolescent Unit doesn’t communicate well with CAMHS or YouthLink especially when discharging high risk people.

- Allied health staff can’t refer direct to the BAU so you have to go through the ED.

- It was intended that the CERTs would have a child and adolescent liaison officer, but this didn’t happen.

- It was easier to get face to face contact for clients when we had PET. There is now another step involved with CERTs and they don’t always respond.

- An area that has worked well has been the Youth Self Harm Social Worker, particularly at RPH ... explaining and negotiating ED processes ... providing follow up information ... and ongoing support for the client.
Learning From Others ….

South Metropolitan AMHS
- Area MHS
- Fremantle
- Bentley

New South Wales
- DOH
- Royal Prince Alfred
- St George’s
- St Vincent’s
- Royal North Shore

Victoria
- DOH
- Southern
- Inner West
- Alfred
- Peninsula

International
- Winnipeg Regional MHS
- Maudsley/King’s College

Extensive Literature Review
Learning from Others.....Overview

Hospital-based
- Emergency Department
  - Separate Stream
  - KPI [4/8/24]
  - PECC SSU
  - Inpatient Unit
    - PAPU
    - Bed Flow
  - Bed Flow

Community-based
- MHERL
  - MH Telephone Access Line
  - Info, advice referral call line
  - Area Triage
  - Pacer
- CERT
  - CRHT
  - CATT ACCT
  - PARCs Crisis Houses
  - ‘Integrated’ Model
  - CMHS AST CCT
Learning From Others .... Peninsula MHS

Richard Newton, Austin Health

- Population 260,000 around Frankston area, Victoria
- Had typical Victorian set of services [e.g. CATT/ECATT, CCT, PMH, MST, EIP] all run as discrete teams
- CATT presented considerable barrier to entry and seen by consumers and carers as a problem – wanted ‘early episode’ access

  Identified that only about 38% of processes added value [e.g. repeated assessments – “tell their story many times, but much information is not used or lost”]

- Moved to an ‘integrated’ model of care rather than ‘silos’ & created 4 geographic teams
Learning From Others …. Peninsula MHS [continued]

- Triage – everyone must leave with “a service arrangement in place”
- Systematically developed partnerships – GPs, PDRSS, Carer Council
- Bed occupancy almost immediately fell from close to 100% to 85% - “getting rid of CATT led to a doubling of acute assertive outreach that people were receiving early in their episode”
- Important principles:
  - Easy in, easy out, no refusal
  - Focus on intervening early in episode
  - The more steps in a process the more opportunity for error
  - Cumulative assessment rather than repeated assessment
  - Separation of function leads to discontinuity and loss of momentum
  - Small integrated teams mean that teams ‘own’ their clients
  - Case management is a ‘system’ and not an ‘intervention’
Combined CERTs: Age Distribution and Service Use

![Combined CERTs: Age Distribution and Service Use](image)
Combined CERTs: Child and Youth Service Use

Age

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<tr>
<td>17 Years</td>
<td>11</td>
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Combined CERTs: Child and Youth Service Use
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Referral Source

- MHERL 61%
- Adult Clinic 15%
- CAMHS 6%
- ED 3%
- BAU 3%
- Police 12%
Child and Youth Use of Other Emergency Services

PMH ED 2006/07 - 897 Mental Health Occasions of Service

Estimated Use of Other Emergency Services

• MHERL Whole Metro – About 120 X 10 - 14 year olds & 720 X 15 – 19 year olds per annum

• EDs North Metro – Between 350 and 450 people 17 or under [mainly 16 and 17 year olds]
Entry Points and Pathways

Emergency Referral
- Self/Family
- GP/Specialist
- Police
- Ambulance
- Other

ACIT
PMH ED
General Hospital EDs
MHERL
CERT
CMHC

Discharge
Non-emergency Referral

CAMHS Clinics
Clarkson
Hillarys
Swan Kalamunda
Warwick Mirrabooka
Shenton

GPs
School
CDS
DCP
Other
Reflections …

- CAMHS has very little capacity currently for the assessment and management of children and young people in crisis and relies on PMH ED and the adult emergency mental health system [EDs, CMHS, MHERL and CERT].

- There is no real recognition of the emergency services as part of the ‘CAMHS system’ – no acceptance of the assessments or priority given to the clients.

- CAMHS model and entry criteria of severe, complex, persistent disorder do not support the important principle of early intervention.

- ‘Triplication’ – triage by emergency services, then by CAMHS central triage, then by the team. A lot of resources are going into screening people ‘out’ - underlying fear of being ‘swamped’.
Reflections ….

- PMH has dealt with the difficulty of accessing CAMHS by developing ACIT, its own intensive community treatment and support service.

- Lack of coordination between CAMHS and PMH, EDs, CMHS and MHERL/CERT.

- Limited shared care/responsibility with other agencies providing services to young people and with private practitioners.

- No shared policy or connectedness between the Bentley Adolescent Unit and CAMHS.

- It is not clear where YouthLink fits into the CAMHS and Adult MHS.
Where to From Here .... Some Staff Views

- ACIT type team north and south supporting triage and enabling a community acute response – after hours shared between north and south.
- Collaboration between CAMHS and ACIT.
- Shared appointments between CAMHS and ACIT.
- Combine CAMHS and ACIT and provide community inreach into ED.
- “Open out front end” - have face to face consultation with everyone.
- Improve access to CAMHS by reducing layers of gatekeeping.
- Have one CAMHS Directorate (including PMH MHS) for Perth.
- Improve consultation/liaison services with all EDs.
- Manage crises at a site other than PMH ED.
- Role for YouthLink to support CAMHS with 16 – 18 year olds.
- Quarantine beds at Ellis Unit for 15 – 18 year olds.
The Principles Underpinning the Review……

“There was strong advocacy for a greater emphasis on prevention, promotion of positive mental health, early intervention – earlier in the life course as well as in the course of an illness – and for more sustained, flexible and comprehensive support delivered in the community.”

Because Mental Matters, Victorian Mental Health Reform Strategy 2009 - 2019

Principles underpinning this Review of Emergency Mental Health Services are:

- Early intervention in the course of illness/episode
- No wrong door: easy access to assessment and direction to the right service in a timely way
- Working jointly with partner agencies to provide individually tailored treatment.
- Flexible support delivered in the community or in the most appropriate and least restrictive environment.
- Meaningful engagement of consumers and families.
The ‘Emergency’ Continuum

Where and how does CAMHS fit into this Continuum?
Emergency services for children and young people are currently being provided primarily through General Hospital and PMH EDs, with MHERL/CERT providing a relatively small but important role.

Without a very significant increase in resources, CAMHS would not be able to provide an emergency response for the low volume, high urgency end of the continuum.

Question

How can CAMHS improve the quality of the services currently being provided for children and young people by the emergency mental health system?

- No re-triaging and priority entry to CAMHS?
- Pro-active follow-up of clients post-emergency presentation?
- Shared care with adult services?
Working Together To Provide Age-Appropriate Environments And Services For Mental Health Patients Aged Under 18

A briefing for commissioners of Adult Mental Health Services and Child and Adolescent Mental Health Services

June 2009
Reducing the Burden of Self-Harm in Children in Hartlepool

The CAMHS team in partnership with the acute service at the local hospital has developed protocols and standards for practice around deliberate self-harm. If a young person presents at A&E with self-harm they will be admitted to the paediatric ward if they are under 16. If they are over 16, overnight admission for medical and mental health assessment is encouraged, but some young people refuse and decide to go home. A member of the CAMHS team, operating on a rota basis, will ring A&E each morning at 9.30am to enquire whether any young person has presented with self-harm during the previous 24 hours. If so, then within 24 hours a member of the team will visit the young person, whether in hospital or at home, in order to make an appropriate mental health or risk assessment.

Most young people are responsive but if the young person refuses to engage with the team, their GP is alerted and made aware of the issues. The team is also trying to bring school nurses into the loop by sending them discharge summaries so that schools are aware of the situation and can be supportive.
Emergencies are not fixed but on a continuum and early intervention can prevent escalation.

The secondary referral model does not facilitate early intervention – particularly important in youth.

There is general recognition in the sector of a need for some kind of intensive community treatment and support service like the ACIT model.

Question

How can we improve the responsiveness of the child and youth sector to facilitate earlier access and intervention?

- Area triage for all age groups?
- Direct access to triage and assessment?
- Development of intensive treatment and support services with extended hours operation?
- Emergency appointment system?
The Community Intensive Treatment Team, South Wales

The CITT was created in 1998 to serve young people who needed more care than was possible in conventional outpatient clinics as it became apparent that many of these cases were being lost to the system or needed admission to psychiatric units far distant from young people's homes or into adult wards. The team works on multi-systemic therapy principles, providing motivational interviewing / engagement, and as appropriate – family therapy, behavioural therapy, cognitive therapy, medication, networking, health education and social services. The team has found that their work blends well into family life, leading to better outcomes for the young person. Under 10% of the young people cared for by the team go on to need admission to an adolescent inpatient unit, but continued support by the CITT ensures that young people have a safe and appropriate discharge as soon as possible back home. Young people may be cared for by the CITT for up to a year. The costs of providing intensive community support for the majority of young people are much less than the equivalent inpatient stay.
Challenging the Tiered Approach ….

- Tier 1 and 2 responsible for case finding and ‘escalation’
- ‘Pass the person’ to the level of care rather than ‘share the care’
- Does not support concept of early intervention to prevent emergencies
Collaborative Care Model ….

Care Coordination

- Specialist MHS
- Independent Professionals
- Primary or Direct Contact Services
- Other Human Service/Support Agencies

Individual Care Plan

- Person-family centred with professionals moving in and out of the Individual Care Plan
- Early intervention to reduce emergencies
- Multiplies capacity through sharing care and skills enhancement
- Reduces barriers between services
Question:

Is the Collaborative Care model able to be implemented within CAMHS and, if so:

- What would be the benefits and drawbacks?
- Barriers to implementation?
Worcestershire Early Intervention Psychosis Service

Worcestershire Early Intervention Psychosis Service (EIS) offers early intervention to the full age range from 14-35 years. It has an EI CAMHS case manager post funded from CAMHS grant monies who offers dedicated case manager support to the under 18s. The team from adult services works in an integrated way with CAMHS colleagues in the support of under 16s and have a clear protocol as to how it works together across the age transition in the support of 14-16 year olds with first episode psychosis. The EI team sits on the CAMHS multi-agency steering group with colleagues from CAMHS, local authority, youth services and education.
Key Decision Point 4 ..... Creating a System

CAMHS, BAU, YouthLink and PMH have a mandate for providing child and adolescent mental health services, but they do not operate as a coordinated service system [e.g. complementary admission criteria or policies, shared protocols, shared care]

Questions:

- What might such a service system look like?

- What would be the advantages/disadvantages?
Assertive Outreach for Adolescents

Adolescent Assertive Outreach model
(South West London /St George’s MH Trust)

This is an integrated highly specialist service consisting of an outreach team, 8 bed acute unit and day programme, for adolescents 12-17, (but patients are mainly 15 to 17 year olds) presenting with serious mental illness, where inpatient admission is considered. It aims to avoid or reduce inpatient care wherever possible through the use of intensive outreach. It is commissioned by five South West London Boroughs through a consortium with a lead PCT, where all share the risk but with the stability of committed funds.

Although the team does have access to beds, (eg for part week stays, crisis admission, day programme) most of the work is undertaken in homes, as well as clinics, schools and environments where young people feel comfortable such as parks.

The outcomes include highly dependent patients being managed with little use of Psychiatric Intensive Care Units; few ‘blocked’ beds; no private beds used; admissions to adult beds are rare; length of stay in CAMHS beds for most patients is less than three months.
Group Discussion

1. Key Decision Point .... Working with the Emergency Services

2. Key Decision Point .... Intervening Early

3. Key Decision Point .... Multiplying Capacity

4. Key Decision Point .... Creating a System