Future Directions Workshop
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Outline of Presentation

- Review objectives/scope/process
- Themes from consultations
- Reflections
- Learning from other jurisdictions
- Principles underpinning the review
- Where to from here in WA?
  - Key decision point 1 - Access
  - Key decision point 2 – Emergency care in the community
  - Key decision point 3 – EDs and beds
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:
  - ED
  - 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
- Emergency Department
- Inpatient Unit
- CERT
- CMHS
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

MHERL

Hospital @ Home

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
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 Youth and Older Adults
6. Operational Issues
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 Youth and Older Adults

**Services for Youth**

- CAMHS and Youthlink have a limited ability to respond to emergencies and try to negotiate with the adult system. But there is no clear systematic approach across the adult program. This extends to EDs.
- 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.
- It was intended that the CERTs would have a child and adolescent liaison officer, but this didn’t happen.
- CAMHS don’t seem to understand the nature of the work in ED. Sometimes we get a standardised response from them 2 to 3 weeks later saying that the person has not been accepted.

**Services for Older Adults**

- Most emergencies in this age group have medical co-morbidities and we want them to have a medical assessment before they come to the older adult program.
- The PLNs are resourced to do all assessments and should be able to assess older aged clients.
- Setting up a parallel system with the adults is not feasible.
- It has been more difficult for older age psychiatry since the PLNs were established in EDs. They have mainly trained in adult psychiatry and are not good at excluding organic states. We have offered educational programs but the uptake is low.
- With the older adult services there is a constant battle. They want a full-blown psychogeriatric assessment with each client. We generally manage to get them to come to ED but with lots of complaints.
Operational Issues

**CERTs**
- Scope of role
- ANF/HSU positions
- Award level
- Reporting lines
- On call roster
- Supervision and training
- Medical backup

**PLNs**
- Clarity of role
- Reporting lines
- ‘Medical clearance’

**CMHTs**
- Role of w/end services
- Medical backup w/end

**MHERL**
- ANF/HSU positions
- Clarity of role
- Isolation

**H@H**
- After hours staffing
- Scope of service
“They say that you have to take responsibility and then when you do and ask for help, they tell you that you’re not sick enough”.

“When it gets to be an emergency, it’s too late”.

“To be sick, you have to be very healthy”.

- Difficulty of access
  - Knowing where to go
  - Getting a response
- Alternatives to hospital
- Peer support workers
- Shared care in private/public
- ED and Police unpopular options
“We didn’t know where to go for help. No-one told us about the community emergency team”.

“The community emergency team works well. It falls down when you get to ED and hospital”.

“As ‘carers’ or more accurately the people that have to pick up the pieces when things go wrong, we are not provided with any information”.

- Navigating the system
- More skilled Ambulance/Police
- ED negative experience
- Carers ‘ignored’
- Shared care in private/public
Reflections ....

- Once people get access to MHERL/CERT – generally satisfied with service they get

- Consumers and families have difficulty knowing where to go, accessing and navigating MHS

- MHERL is isolated and its role unclear

- Roles, policies, procedures and protocols of CERTs, PLNs, and EDs across Area are all different – ‘Postcode Lottery’

- Large investment of resources triage/assessment of emergencies and not enough on ‘prevention’ of emergencies [what is triage?/Assessment Team model/intensive support]

- In absence of adequate CMHS, EDs become major entry point MHS, especially after hours, for urgent assessment [resourcing and appropriateness/consumer- carer experience]

- Access to acute IP beds - some improvement - BUT still major problem [EDs ‘holding beds’/ED ‘reliable portal’/4 hour rule/resource use/impact staff/BF Coords v. local ownership]
• Community emergency response ‘system’ – CMHS/CERT/MHERL – not ‘sustainable’ in current form [emergency v. clinic business, distribution CERTs/work, operational issues]

• No clarity of role or operation of weekend CMHS [resource use]

• Limited options in emergency – no alternatives to IP beds

• Fragmentation between and within services [continuity of care CMHS/IP, ATs v. CCTs, information/communication]

• Role of ‘specialised’ [H@H, Transition Program, DBT ] v. ‘integrated’ programs

• Role of Police needs resolving [continuing role emergency, but ? Transportation/ consumer-Carer attitude ]

• Partnerships – use of GPs, private sector, NGOs
Learning From Others .... Information and Access

Victoria

- Developing state-wide 24/7 information, advice & referral call line
- Southern Health - centralised 24/7 triage service [all age groups]
- Policy of ‘no wrong door’
- Peninsula policy of ‘easy in, easy out, no refusal’

New South Wales

- 24/7 State-wide Mental Health Telephone Access Line
- ‘Combining’ triage services within regions [e.g. St George’s/Sutherland]

Southport/Formby, Liverpool, UK

- Direct triage to ‘emergency appointments’
Learning From Others .... Emergency Department Use

Victoria

- ECATT – ‘in-reach’ [Alfred] OR ‘dedicated’ [Royal Melbourne]
- Direct consumers to ED after hours
- ‘Alternative beds’ Royal Melbourne - Short Stay Unit/PAPU
- Nurse Practitioner [Alfred]

New South Wales

- PECCs – ED Liaison + beds [St George’s, St Vincent’s]
- RPA – Nurse Practitioner BUT no PECC
- Direct consumers to ED after hours

International

- Separate entry- Mental Health Crisis-Response Centre [Winnipeg RHA]
- Shared entry, separate pathway [King’s College Hospital, UK]
“… it offered the most fundamental characteristics that users require from a crisis service, i.e. open access, 24 hour, seven days a week specialist service provided by mental health staff in a quiet and discrete environment. Since the closure of the Emergency Clinic, local users have been left without these crucial facilities i.e. Community Mental Health Teams still close their doors at 5:00 pm and over the weekend, mental health Home Treatment Teams can only be accessed via a professional referral. The only self referral option for mental health users experiencing a crisis ‘out of office hours’ is to go to King’s College Hospital emergency department. … We have been told that a separate mental health area would be ‘stigmatising’. As people with direct experience of mental health crisis and facing considerable prejudice due to our mental health needs, we strongly object to being told that the safest and most appropriate way for us to access help when we most urgently need it, is stigmatising. … We would argue that being stared at by members of the general public because we ‘look funny’ or are talking to our voices or crying out with the pain of distress is far more stigmatising and very unsafe.”

Theresa Priest, Coordinator, Southwark Mind
April 2009
Learning From Others …. Community Response

Victoria

• CATT operates to 10:00 pm [ED A/H/resources/NOT ‘front line’]
• Review of CMHS [Southern/’merged’ model]
• Police/Ambulance role
• PACER [Southern]

New South Wales

• Acute Community Care Team operates 10:00 pm [ED A/H/resources/NOT ‘front line’]
• ACCT role – assess/STT/early discharge/Intensive community support
• Review of CMHS [SESIAHS/Royal North Shore]
• Police/Ambulance role

SMAMHS

• Bentley MHS extended hours service
• SMAMHS Review [re-establish centralised system with coordinator]

International

• Crisis Resolution Home Treatment Teams UK
Learning From Others …. Beds

Victoria

- KPIs – 4/8/24 hours [State-wide/escalation policy]
- Managing flow [Southern/Inner West]
- Managing beds across region [Western Health/PAPU]
- Impact of bed flow policy on staff [Inner West]
- Alternatives beds - PARCs – CATT/NGO partnership

New South Wales

- KPIs – 4/8/24 hours [State-wide]
- Managing flow [SESIAHS]

International

- Alternative beds - Crisis Houses [MHS/NGO partnerships UK]
Learning From Others .... Integration

Victoria

- CATTs ‘glue’ between community – IP services

New South Wales

- ACCT ‘glue’ between community – IP services
- Royal North Shore bringing CMHC on hospital site

SMAMHS

- Fremantle MHS – an integrated service
Learning From Others …. Fremantle Model

Referral

ED

Liaison

Triage

CERT

Inpatient – Community Team

Inpatient – Community Team

Inpatient – Community Team

Early Episode Psychosis Team

Intensive Rehab Team

Consultation/Liaison Positions

- Accommodation
- Women at Risk
- Aboriginal

- Multicultural
- Dual Diagnosis
- General Practice

Living Skills Centre
Learning From Others .... Peninsula MHS

Richard Newton, Austin Health

- Population 260,000 around Frankston area, Victoria
- Review IP services & then moved to review community services [Six Sigma]
- 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
- Adopted a ‘Care Bundle’ approach – every patients must get access to a bundle of EBIs
Diagnosis of Schizophrenia

Psychosocial Interventions For Schizophrenia

Consider at each stage
- Assessment of individuals needs
- Risk assessment (clinical & social)
- Willingness and capacity to engage
  - Legal Status
  - Physical health
  - Cultural issues
  - Other supports
  - Comorbidity

Source: Dr Richard Newton

 brokerage
Broker specialist service from external agency but ongoing role in liaison & coordination

Yes Partially
- Can these needs be met outside the Mental Health Service?
  - Yes Fully
    - Refer to appropriate external agencies
  - No
    - Case management - coordination of services
    - Case management - direct service provision
    - Broker specialist services from within MHS

Three monthly clinical reviews to assess treatment needs, goals, progress and discharge planning
Learning From Others …. Peninsula MHS [continued]

- Triage provided by teams till 5:00 pm and then roster from 5:00 to 9:00 pm – everyone must leave with “a service arrangement in place” - ‘frequent fliers’ go back to previous clinician

- 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’
Summarising ....

Hospital-based

Emergency Department

KPI [4/8/24]

Separate Stream

PECC SSU

Inpatient Unit

PAPU

Bed Flow

Community-based

MHERL

MH Telephone Access Line

Info, advice referral call line

Area Triage

CERT

Pacer

CRHT

CATT ACCT

CMHS AST CCT

PARCs Crisis Houses

‘Integrated’ Model

Integrated Model

Area Triage

KPI [4/8/24]

Separate Stream

Emergency Department

Emergency Department

Inpatient Unit

Inpatient Unit

PAPU

PAPU

Bed Flow

Bed Flow

MH Telephone Access Line

MH Telephone Access Line

Info, advice referral call line

Info, advice referral call line

Area Triage

Area Triage

CERT

CERT

Pacer

Pacer

CRHT

CRHT

CATT ACCT

CATT ACCT

CMHS AST CCT

CMHS AST CCT

PARCs Crisis Houses

PARCs Crisis Houses

‘Integrated’ Model

‘Integrated’ Model
The Principles …..

“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
- Continuity of care: taking responsibility for ‘journey’ and not simply ‘episode’ of care
- Care ‘closer to home’ and in the least restrictive environment
- Meaningful engagement of family carers
Where to from here in WA?

- Add Beds
- Alternative Beds
- 4-Hour Rule
- ED
- ‘Litmus’
- Alternative Entry
- Psychiatric Inpatient Beds
- Bed Strategy Flow Coordinators
- Highly reliant on bed solution
- Subacute Beds
- Intensive Treatment
- Community Emergency Services

Bed Strategy Flow Coordinators
Highly reliant on bed solution
Key Decision Point 1 ..... Access

Background:

• Consumers and Carers find difficulty in knowing how to access emergency MHS

• MHERL is not promoted within the community

• Is MHERL an ‘emergency/triage only’ or does it have a broader role?

• MHERL has no authority to direct an MHS service response

• Each MHS has its own triage officer system and entry criteria

• There is considerable duplication of effort with re-triaging
Key Decision Point ..... Access

Questions:

• If MHERL is unable to direct the service response ['triage'] but primarily providing information, advice and counselling, do we need MHERL or could these functions be carried out through Health Direct?

• Could MHERL take on an Area-based triage function for all age groups similar to Southern Health in Victoria and, if it did, would we need all the existing triage services?

• Could we have a single MH access line similar to the NSW model which transfers calls to Health Direct [for information only] or to District/Area-based triage services?
Background:

- Consumers and Carers want access to care early, at home where possible
- Strong support for intensive community treatment and support
- Integrate CERTs into community teams to provide extended hours services - but how?
- Questioning the value of w/end and Area-wide services
- Small number of ‘real’ emergencies – competing demands for CERTs
- Recognition that on-call system for after-hours emergencies is unsustainable
- There is no after-hours community medical support for emergencies, other than MHERL
- There needs to be clarity in the ‘emergency’ role of MHS vis-a- vis the Police
- There is currently very limited community emergency response for youth & older adults
Questions

- What is the role of CMHS in providing a low volume emergency response?
- Can this low volume emergency response be provided as part of an ‘integrated’ CMHS or would it be better provided by a small [area/state-wide] specialised team?
- If the CERTs are integrated into CMHS, how will this enhance their capability? Will the emergency response be diminished?
- If we go down the integrated pathway, how can we deal with the distribution of the CERT staff?
‘Separate’ or ‘Integrate’?

Role of ASTT

- Assessment of all referrals
- Short Term Treatment
- Emergency assessment
- ‘Holding’ function for CCT

Questions

- How is it going to help putting more resources into ASTT?
- Have we got too many resources tied up in triage and assessment and not enough in treatment?
- What impact does the separation of responsibilities have?
- What strategies could increase the flow through the system?
- Which processes add value and which don’t?
Threshold for Admission ….

Admission threshold is not ‘fixed’

“If community teams had their own intensive home treatment service, they would hang on longer, knowing that there was extra support.”

Stakeholder Consultation

Questions

• What is the common understanding of Intensive Community Treatment and Support?
• How could this function best be provided within CMH Services?
• How could this function best be provided within existing resources?
Key Decision Point 3 ..... EDs and Beds

Background:

- Consumers and Carers want open access to specialist mental health services provided in a quiet discrete environment – not the standard ED
- EDs have become ‘holding beds’ for access to psychiatric beds and substitutes for lack of after-hours community MHS
- Extended stays in ED waiting for a bed are clinically unacceptable
- Difficulty in accessing mental health beds comes at a high ‘cost’ to EDs & CMHS
- Substantial problems associated with inter-hospital transfers
- Limited involvement of CMHS in the patient journey through EDs and IP services
- While the focus of the 4 hour rule is on the ED, the solutions lie elsewhere
- Managing ‘bed flow’ is essentially about changing clinicians’ practices
- The current model of MHS delivery in ED does not properly reflect the service need [youth, older adult, drug and alcohol, multi-disciplinary]
EDs and Beds ….

Questions

- How can we improve EDs for mental health clients?
- Should we be considering alternatives for ED - walk-in crisis centres, near ED or in the community?
- Can we resolve our bed problem without having to develop special beds like PECCs & PAPUs?
Small Group Discussion

1. Key Decision Point .... Access

2. Key Decision Point .... Emergency Care in the Community

3. Key Decision Point .... EDs and Beds