Intermediate Care Workshop
18 February 2008

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Intermediate Care – What is it?

- Term first coined in aged care area
  - Short-term [< 6 weeks]
  - Intensive rehab & or intensive treatment
  - Aim to prevent unnecessary admission, facilitate early discharge or prevent premature admission to permanent residential care
  - Provided in a range of settings including own home, sheltered housing, day hospital
“Intermediate care provides individualised intensive programs in a therapeutic, home-like environment. Services aim to prevent hospitalisation and provide early intervention in the community facilitating return to independent living and integration in the community.”

Mental Health Division
Department of Health WA
The intermediate care program will consist of 47 beds variously described as:

- Primarily step-up services to divert people from hospitalisation
- Provide clinical in-reach treatment and short-term non-clinical support
- Not a substitute for inpatient admission
- Not intensive rehabilitation but targeted at early discharge and rehabilitation readiness
To expand the range of options for people in the acute phase of a severe mental illness

To supplement crisis intervention services

Intensive clinical intervention and treatment

Offers level of services between acute inpatient setting and usual place of residence

Maximum length of stay 12 weeks
Nature of the proposed service is not clear

Basic problem the ‘apparent’ lack of inpatient beds

Mental Health Inpatient Snapshot Survey 1 March 2006 showed:
- 45% could have been discharged if there were appropriate alternative services; and
- of these, 35% required intermediate care
Thinking Systemically

Hospital

1. Crisis Intervention & Home Treatment
2. Crisis Housing
3. Acute Care
4. Early Discharge
5. Day Hospital
6. Intensive Case Management
7. Extended Care
8. Supportive Housing
9. Increase Bed Numbers [Acute/Rehab]

Supportive Housing

In-reach Program

[Diagram showing flow between various care settings and interventions]
Alternatives to Inpatient Care

- Number of different groups currently using inpatient beds who could be treated in, or discharged to, alternative settings

- Raises 3 key questions:
  - What actually is Intermediate Care?
  - Which group[s] is this program targeting?
  - How will it be integrated within the system?
Specific Examples

- UK – Crisis Resolution and Home Treatment Teams [CRHT]
- Victoria – Prevention and Recovery Care Services [PARC]
Crisis Resolution & Home Treatment Teams [CRHT]

- Set up as ‘gatekeeper’ - acute, short-term home treatment as alternative to hospital admission or enable early discharge
- 343 teams across UK [Audit Commission, 2007]
- Rapid expansion between 2001-2004
- Intended to operate 24 / 7
- Treatment in range of settings [home, respite facility, crisis house]
CRHT - Defining the Issues

- Significant reduction in admissions – but variation across sites, age groups
- Lesser reduction in bed-days
- Impact on different diagnostic groups unknown
- Not all CRHTs staffed for 24/7 operation
- Need to be “fully functional and integral part of acute mental health services”
- Recommending ‘coordination’ with inpatient services [co-location, monitoring inpatient stays, integrated training, staff rotation]
- More alternatives to ‘home’ for treatment [e.g. S. Warwickshire/Rethink ‘crisis house’]
Prevention & Recovery Care (PARC)

- Step-up/step-down
- Established 2003
- 3 operational, 4 approved, 7 more over 4 years
- 10 beds – ALOS 14 days, maximum stay 28 days
- AMHS contracts with PDRSS NGO for 24/7 support
- In-reach clinical services – Crisis Assessment & Treatment Teams [CATT]
- MOU between NGO & AMHS with joint oversight committee
- Approx $1.2 M pa [$100/bed/day less than IP]
Defining the Issues - PARCs

- Tension between ‘acute’ and ‘rehab’ roles [e.g. CATT vs Rehab Teams, PDRSS support]
- ‘Residential’ versus ‘day’ places
- Concerns about ‘step-down’ function amongst some AMHS
- Have PARCs reduced use of inpatient beds or provided additional beds?
- Evaluation underway [report due March 2008]
Both programs, particularly CRHT, focus on the acute care side of the picture – preventing admission or facilitating early discharge.

Treatment at home or in alternative community settings is safe and effective – preferred by consumers.

There are few absolute reasons for hospital vs community treatment [level of risk, need for coercion, availability of family/other supports].
Learning by Example [Continued]

- Need for close coordination with the acute care system, particularly inpatient services
- Having a well-resourced team, including importantly a psychiatrist, to provide the clinical services
- Growing recognition in UK of need for alternative treatment settings [e.g. crisis houses]
- Short-term and not a substitute for housing
  - LOS 2 weeks .... throughput 1220 per annum
  - LOS 4 weeks .... throughput 560 per annum
  - LOS 12 weeks .... throughput 190 per annum
Considerations for WA

- **Clarity about the purpose of the new facilities**
  - Target population?
  - Real alternative to acute hospital admission?
  - Intermediate suggests ‘in-between’ – separate thinking about location, treatment type and service intensity
  - Bed-based systems have blocks and bottlenecks

- **Its fit within the broader mental health system**
  - Consider linkages with, and impacts on, existing services
  - Who provides clinical care? WA does not have the equivalent of CATT or CRHT teams – acute care variable & fragmented
  - Linked into community or hospital services? [Gatekeeping/incentive]
  - ‘Spectrum’ of acute care service localities? [home, crisis house, acute day patient program, respite facility, inpatient care]
Considerations for WA [Continued]

- Ensuring the right configuration
  - Optimal size and location?

- Clarity about the roles of the NGO support and clinical care providers
  - Who controls admission?
  - Management of medication?

- Clarity about the operational policies
  - Standard policies across program
  - Clear policies on emergency management and hospital admission