WHAT WOULD A MODERN, EFFECTIVE COMMUNITY MENTAL HEALTH SERVICE LOOK LIKE?

Presentation to SMAHS Mental Health Clinical Models Group
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What we have done ……

- Review of Inner City Community MHS
- As part of the above we examined the structure and function of:
  - Mirrabooka
  - Fremantle
  - Rockingham/Kwinana
- Undertook research and provided advice to Division and MH Sector on Intermediate Care and Rehabilitation and Recovery
- Currently reviewing Hawthorn House
- Reviewed the Independent Living Program and provided advice on models of housing
Rockingham/Kwinana model

Referral -> Triage

- Community Team 1
- Community Team 2
- Assertive Community Team
- Intensive Day Therapy Program
- Living Skills Program
- Early Episode Psychosis Team
- Ruah

CERT
Fremantle model

Referral
- ED
- Liaison
- CERT

Triage

Early Episode Psychosis Team

Intensive Rehab Team

Inpatient – Community Team

Consultation/Liaison Positions
- Accommodation
- Women at Risk
- Aboriginal
- Multicultural
- Dual Diagnosis
- General Practice

Living Skills Centre
Service Organisation

- Each MHS has unique structure and range of services – owes more to local development
- Significant differences between MHS in north and south
  - Catchment populations
  - Combined inpatient – community services
- Arrangement in south facilitates greater range of services and integration
Catchment Populations

- Clarkson: 40,000
- Joondalup: 183,000
- Osborne Park: 116,000
- Subiaco: 85,000
- Inner City: 75,000
- Mirrabooka: 58,000
- Swan: 189,000
- Morley: 107,000
- Bentley: 216,000
- Fremantle: 199,000
- Rockingham/Kwinana/Peel: 177,000
- Armadale: 124,000
Building Viable Services

- Larger populations provide more viable base for planning, development and management of comprehensive range of MHS

- UK DoH plans new specialised teams:
  - Crisis Resolution Home Treatment 1 per 150,000
  - Assertive Outreach 1 per 250,000
  - Early Intervention in Psychosis 1 service [3 – 4 teams] per 1M

- Options
  - Networking specialist services
  - Amalgamating catchment areas
Possible Configuration .... ?
Service Components

- Proposed that WA have a systematic approach to service provision and rational resourcing model – ‘suite of services’

- Examples of this approach found in Victoria and UK
  - Victoria – standard services across all areas and systematic introduction of new services
  - UK – ‘new’ community services
### Victorian Suite of Community Services

<table>
<thead>
<tr>
<th>Team Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Crisis Assessment and Treatment Teams</td>
<td>Operate 24 hours a day to provide urgent community-based assessment and short-term treatment.</td>
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<tr>
<td>Mobile Support and Treatment Teams</td>
<td>Intensive long-term assertive outreach teams that operate extended hours, 7 days per week.</td>
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<tr>
<td>Continuing Care Teams</td>
<td>This is the largest component and provides clinic-based, non-urgent assessment, treatment and continuing care.</td>
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<tr>
<td>Primary Mental Health and Early Intervention Teams</td>
<td>Consultation/liaison and training for GPs in the management of low &amp; high prevalence disorders and provision of short-term treatment for high prevalence disorders.</td>
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<td>Homeless Outreach Services</td>
<td>Work in partnership with other agencies providing services to homeless people with mental illness using an assertive outreach approach.</td>
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<tr>
<td>Youth Program – Early Psychosis Services</td>
<td>Provides Early Intervention in Psychosis service for people aged 16 to 25.</td>
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UK - The ‘New’ CMHTs

- Concern generic CMHTs could not effectively meet range of demands led to development of ‘functionally differentiated’ model of community service provision
  - Early Intervention in Psychosis [EIP]
  - Assertive Outreach Teams [AOT]
  - Crisis Resolution/Home Treatment [CRHT]

Early Intervention in Psychosis

- Built on observation that long-term outcome is strongly determined by what happens during the initial phase ['duration of untreated psychosis']
- Shorter DUP associated with less severe positive symptoms, improved social functioning and quality of life.

“Implementing the Youth Early Psychosis service requires more than adding just another component to the existing network of mental health services ..... [but] .... to work in a different way; to intervene at an earlier stage of the illness ....”

Youth Early Psychosis Status Report, Victoria, DHS
Assertive Outreach

- Based on the Assertive Community Treatment model [Stein & Test]
- Takes on people who present difficulties – poor engagement services, non-adherence treatment, recurrent admission, substance abuse
- Multi-disciplinary team, small case loads 1:10, 24 hour coverage, community contact
- Benefits include reduction time spent in hospital, increased housing stability, improved medication adherence, reduced substance misuse, better vocational and social outcomes
Crisis Resolution & Home Treatment [CRHT]

- Set up as ‘gatekeeper’ - acute, short-term home treatment - alternative to hospital admission or enable early discharge

- Intended to operate 24/7

- By 2007 were 343 teams across UK

- Audit Commission [2007] recommended:
  - ‘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’]

- Significant reduction in admissions – variation across sites
Enhancing our Community Response

- Growing evidence to support effectiveness of specialised services like EIP, AOT and CRHT

- Argument not whether should be providing these ‘functions’ but how best organised and coordinated with existing services

- EIP in WA for example:
  - Rockingham - separate, stand-alone team
  - Fremantle – integrated into existing community teams
  - Evidence favours latter
People Living with Psychotic Illness

- Peak onset of the psychotic illnesses is in youth [15 to 25]
- Low prevalence study [National Survey, Jablensky 1997]:
  - 71% follow a chronic or intermittent course with incomplete recovery between episodes
  - High levels of social, occupational and domestic dysfunction
  - Nearly half were living in institutions, hostels, group homes or homeless
  - Over half had at least one inpatient admission within previous year
  - Only 1 in 5 had participated in rehabilitation or other programs aimed at improving their functioning
Victorian Rehabilitation and Recovery Care System

- Most developed system in Australia

- Clinical treatment and rehabilitation services provided primarily through the Continuing Care Teams and the Mobile Support and Treatment Teams

- AMHS also provide ‘slow stream’ rehabilitation beds in Community Care Units [333 beds] and Secure Extended Care Units [103 beds]

- Bulk of psychosocial rehabilitation and support services provide through the NGO Psychiatric Disability Rehabilitation and Support Services [PDRSS]
Key Issues for WA

- No ‘system’ for rehabilitation services – e.g. Hawthorn House
- Significant variation – primarily centre based skills development
- Supply of housing and support services significant problem
- Skills base of ‘mainstream’ staff not well developed and no formal training/staff development programs
- Partnerships with NGOs and intersectoral linkages not well developed
### South East Sydney/Illawarra Model

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<th>Level 2</th>
<th>Level 3</th>
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<td>All clinicians able to identify an individual’s rehabilitation and/or disability support needs and facilitate referral to specialist services as needed. All have an understanding of recovery and rehabilitation philosophy and principles.</td>
<td>Clinicians at this level are Working with a rehabilitation Focus. They may be involved in providing components of Packaged rehabilitation programs, Working collaboratively with Rehabilitation clinicians or providing basic rehabilitation Interventions in their everyday Work [e.g. EIP, supported Accommodation, Mobile Intensive Case Management].</td>
<td>Specialist rehabilitation clinicians are trained in and provide individually tailored rehabilitation interventions and services. They act as rehabilitation consultants to the rest of the service.</td>
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Staff participate in **General Training Package**

Staff participate in **General Training Package**

Staff attend **Specialist Training**
Changing Model of Care ….. ?

Course of Illness

Prodrome → Early → Middle → Late

Historical Concept of Rehabilitation

Acute Treatment → Rehabilitation

Rise of Early Intervention Services

Early Intervention → Mainstream → Rehabilitation

Alternative Model

Mainstream Services

Specialist Rehabilitation Clinicians

Psychosocial Rehabilitation & Recovery Services

Prevention and Recovery Care Services
Entry to Services

- Introduction of separate assessment teams at Inner City and Mirrabooka improved time to assessment but question STT role [c. f. CRHT]

- Rockingham has effective triage system but dependent on DO

- Fremantle has well integrated triage system

- Public mental health system primarily targeting people with psychotic illnesses – often at late stage and in crisis ['Gatekeeper']

- Need to develop more accessible and easy to navigate entry points with a stronger triage capacity – ['no wrong door']

- Need to consider CRHT model – with access to ‘intermediate care’
Evidence-based Interventions

- Pharmacological Management
- Assertive Community Treatment
- Family Interventions
- Cognitive Behaviour Therapy
- Cognitive Remediation
- Training in Illness Management Skills
- Integrated Treatment for Co-morbid Substance Abuse
- Skills Training [‘place and train’]
- Supported Education
- Supported Employment
- Supported Accommodation

“...there is at present international consensus that, even in the absence of primary prevention and radical cure, much of the disability and distress associated with the psychotic disorders can be prevented or reduced if the effective interventions and management strategies that exist today are widely available and applied consistently and systematically over the various stages of the illness.”


Lehman et al 2004
Evidence-based Interventions

- Limited range EBIs being provided in routine CMHS
- ‘Generic case management’ central role at expense of ‘clinical specialisation’ – despite findings from Cochrane Review
- Need to invest in the development of specialised skills amongst our multidisciplinary teams to build and sustain delivery of EBIs
- DoH UK has implemented a large-scale training program across England
- Queensland moving in same direction with development of Centre for Mental Health Learning
Expanding Capacity

- Rockingham has a well developed relationship with NGOs working in its area – many other MHSs don’t

- Victoria invests about 12% MH budget on NGO services – sector provides bulk of psychosocial rehabilitation services within PDRSS

- Considerable growth in NGO sector in WA – provides significant opportunity for refocusing public mental health services

- Lesson from Victoria – development of sector needs to be planned with strategies for coordination between sectors/services
Building Partnerships

- Many MHSs in WA have not built strong partnerships with primary care, private mental health, NGO sector, housing, employment, welfare sector, alcohol and drug services.

- Coordination between services and across sectors identified as major problem.

- Public MHS needs capacity to provide consultation/liaison and capacity-building.
Individual Care Plans

- Individual Care Plans being used effectively by EEP service in Rockingham and Hawthorn House, but not widely elsewhere

- ICPs provide a means of coordinating care at the service level across services/agencies - importantly with client and family
What Might a Modern, Effective CMHS Look Like?

Service Elements:

- Proactive approach to identifying clients early
- Facilitate clear and direct pathways to care
- Work closely with primary care to enhance capabilities
- Provide 24/7 emergency response with emphasis on community treatment
- Provide 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
What Might a Modern, Effective CMHS Look Like?

- Introduce routine needs assessment and Individual Care Plans
- Provide a full range of EBIs
- Establish joint working relationship between public and NGO sectors
- Establish strong linkages with the social services system
- Integrate community and inpatient services with community taking ‘lead’ role
- Catchment population large enough to support full range of services [150-250K]
- A systematic approach to providing standard components of CMHS supported by an effective RAM