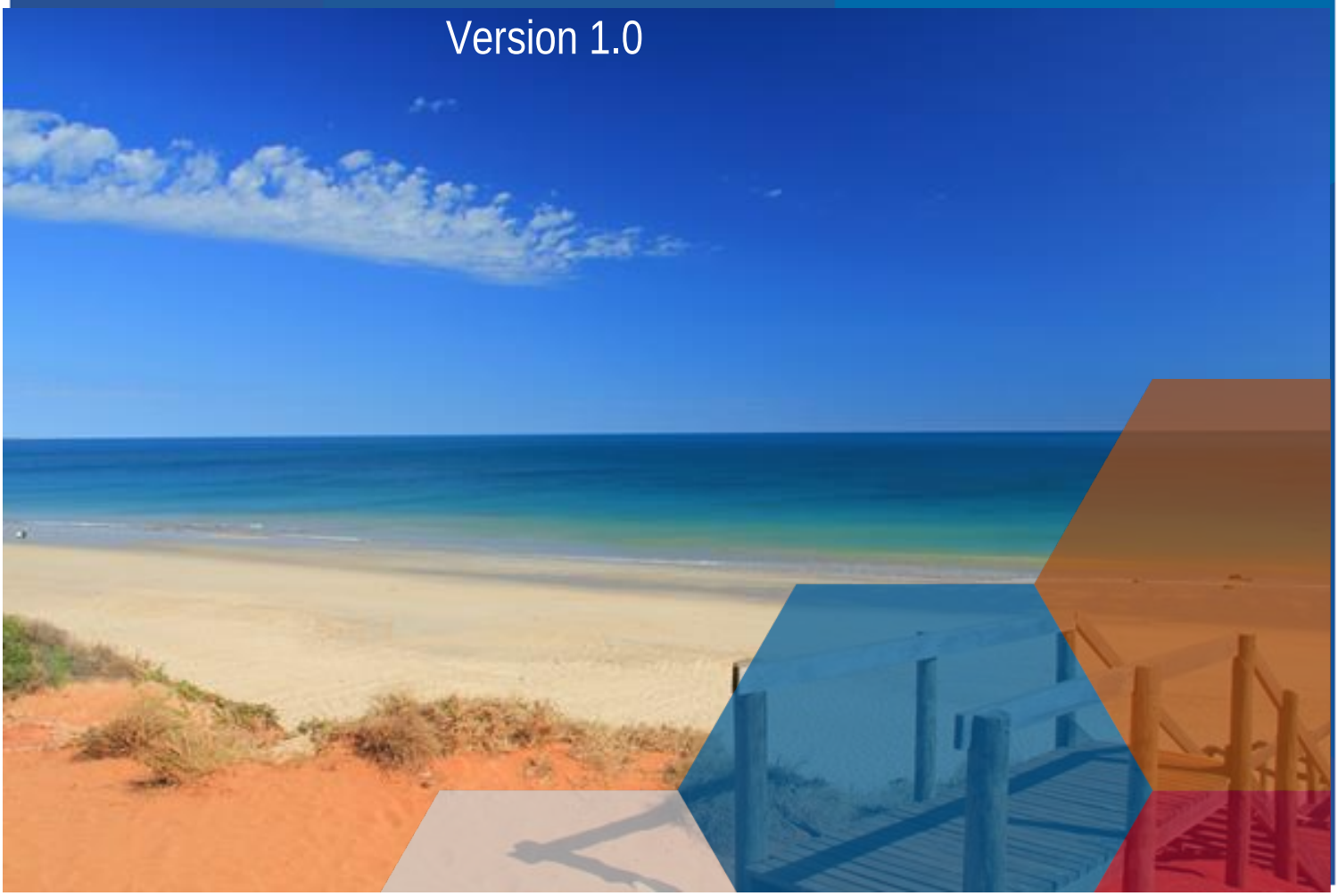
Government of **Western Australia**
WA Country Health Service

Midwest Mental Health and Community Alcohol and Drug Service (MMH & CADS) Model of Care

August 2018

Version 1.0



Contents

1 Introduction

Executive Summary

- Midwest Mental Health & Community Alcohol & Drug Service (MMH&CADS) is undergoing a comprehensive reform process impacting all levels of service delivery.
- We are implementing a new model that will see Midwest consumers of mental health and alcohol and drug services provided with effective and seamless care pathways from entry to exit across all ages, cultures and locations.
- The model development is based on demand led design - a consumer centric and data led process.
- Initial model development identified the need for improved access and entry.
- All referrals will be actioned on the same day
- Eighty percent of clients will have a face to face (including VC) consultation
- Initial face to face consultation will result in completion of a collaboratively designed action plan.
- Entry and access will be managed by a new team - the Advice Consultation Collaboration Entry Support Service (ACCESS) Team.
- The model is designed with a no wrong door approach for all services.
- With improved access and entry the model will accommodate extra demand which will be handled through phased care and appropriate transfer of care processes.
- Care is provided collaboratively, is consumer focused, recovery orientated and trauma informed.
- Care is stepped – care needs are evaluated regularly throughout the client journey and adapted to match the consumers' needs.
- Measures of consumer demand are used to drive improvements.
- The service improvements will be reviewed regularly throughout the reform with ongoing consumer and stakeholder feedback, input and co-design
- There will be improved support and collaboration with general hospitals, emergency departments, acute psychiatric hospitals and other agencies.
- Implementation will begin July 2018 and continue for 18 to 24 months, with a final review in 2020.

Background

Midwest Mental Health and Community Alcohol and Drug Service (MMH&CADS) is a community mental health, alcohol and drug service based in the Midwest health region of Western Australia (see Appendix 1).

The Midwest is bordered by the Pilbara in the north, the Wheatbelt in the south and Goldfields in the east. It comprises four districts; Gascoyne, Geraldton, Midwest and Murchison. It covers more than 600,000 square kilometres; nearly a quarter of the State, 91% is considered very remote. Most of its population, approximately 65,000 people, is concentrated along the coast. Approximately 13% of the population are Aboriginal.

The Midwest region contains areas with very low socio-economic status as indicated by Socio-Economic Indexes for Areas (SEIFA) scores (see Appendix 2). It has the highest incidences of low income, single parent families and unemployed people in the state.

For the period 2011-2015 suicide was the leading cause of death in the Midwest for 15-24 year olds, while simultaneously residents aged 15-64 years accessed community mental health services at a significantly lower rate (10%) than the state average. This is despite having a similar rate of diagnosed mental health problem.

Currently, MMH&CADS provides multidisciplinary assessment, treatment and advice to consumers in the region with moderate to severe mental health and/or drug and alcohol issues. It also provides support to carers, local health services and other agencies that work with people experiencing mental health and/or drug and alcohol issues.

Identification of areas for improvement occurred through:

- Consultation with consumers, carers, staff and key stakeholders
- Multiple service reviews and surveys
- Reviews of clinical incidents
- Consumer feedback through compliments and complaints

Issues that were identified:

- Service responsiveness and availability
- Access to the service
- Ability to provide multidisciplinary treatment
- Communication with referrers and other stakeholders
- Discharge processes
- Resourcing of the Children and Adolescent Mental Health Service (CAMHS)
- Insufficient specialised psychiatric and psychology services
- Collaboration with consumers, carers, other service providers
- Primary-secondary care interface
- Care planning that is consumer, carer and family centred
- Systemic family therapy of CAMHS consumers and their families
- Accurate diagnosis and formulation
- Over use of medication including long acting injectable medication
- Understanding of how shared care works
- Consistent assessment of the impact of mental illness on consumers' and families' lives
- Social inclusion as a strategy to inform service interventions

Though the service has always strived for continual improvement, a major reform process was triggered by the merger of the Central West Mental Health Service (CWMHS) with Midwest Community Alcohol and Drug Service (MCADS) in July 2016.

This merger required physical, procedural and policy changes to both services. Ongoing aspects of that reform included:

- Development of the Hospital Liaison Model of Care
- Establishment of a Memorandum of Understanding (MOU) with Graylands Hospital (GH)
- Additional psychiatric input to the Geraldton Regional Hospital (GRH)
- Improved short term follow up of patients discharged from GRH
- Relocation of CWMHS and MCADS staff to support the integration of the two services.
- An increase in Psychiatric FTE

As the reform process continued it became apparent that more resources were required if the service was going to truly achieve significant and lasting reform. In September 2017 a business case was submitted that was based on improvements to the "front end" of the service, i.e. access and entry and to the Child and Adolescent Mental Health Service (CAMHS). The business case was successful and finances became available in January 2018.

Early stages of strategic planning identified that comprehensive service reform was required therefore the decision was made to develop a new Model of Care integrating all parts of the service, significantly improving the consumer's care experience.

Vision

MMH&CADS will be a centre of excellence for the delivery of effective evidence based assessment, treatment, support and consultation to consumers, carers and other stakeholders in the Midwest Region. The service provided will be consumer centred, recovery orientated and trauma informed. For our consumers, the entry into and journey through the service will be clear, easily navigated and as seamless as possible across all ages, cultures and areas.

Help will be provided in a timely manner commensurate with the consumer's need and embedded in a stepped care approach. The service will be flexible and responsive to the consumer's needs which will be provided in a way that suits them. It will be a culturally secure journey for all consumers. The organisation will collaborate closely with consumers, carers and other stakeholders in care management.

The service will adopt an ethos of 'no-wrong door'. If, in collaboration with the consumer, it is decided that ongoing therapy and support from MMH&CADS is not required, they will be given the support they need to access the most appropriate service matched to their level of function and need.

MMH&CADS will work closely with other health service providers and agencies in the Midwest to support those with mental health, drug and alcohol issues.

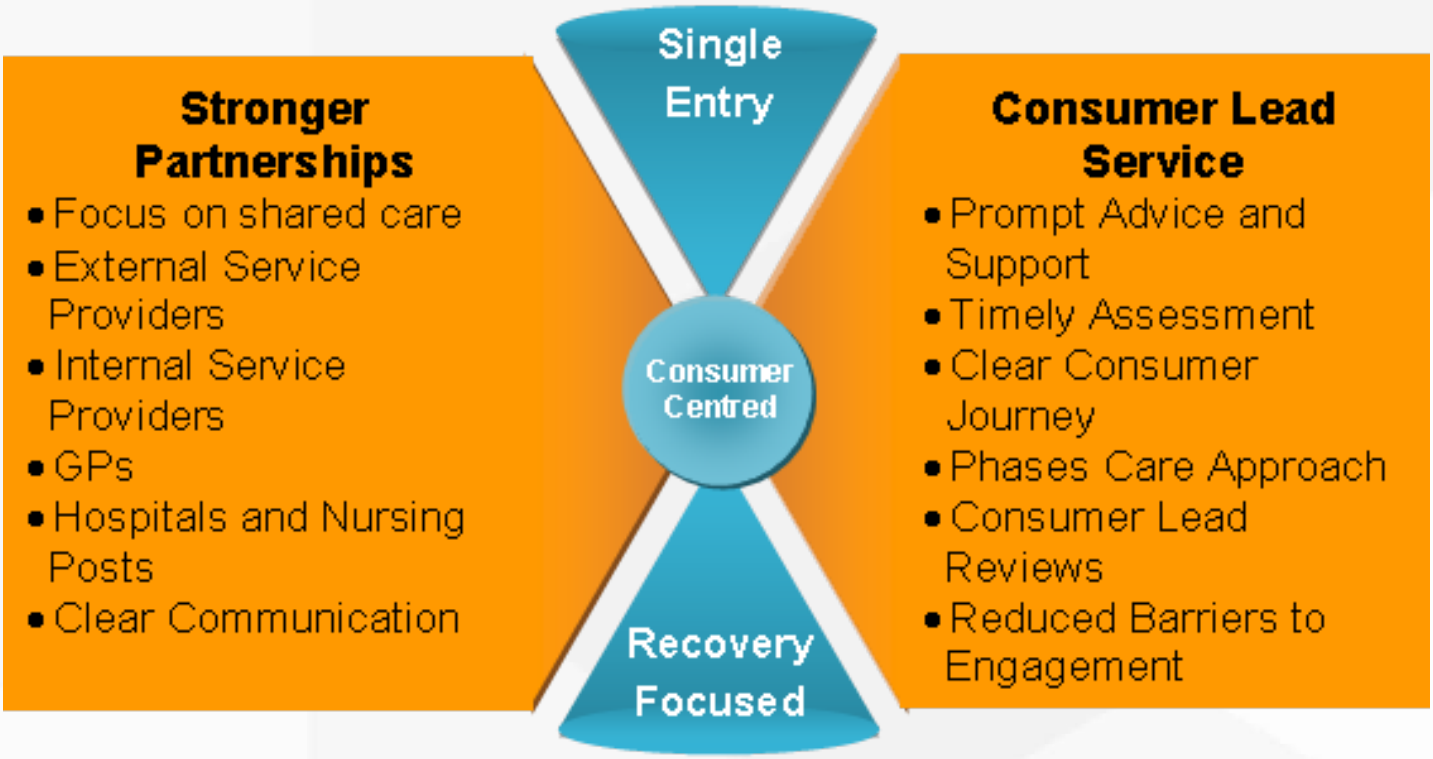


Figure 2. MMH&CADS Vision

Development of the Model

The development of a new model requires a systemic and considered approach. It must meet and then exceed the performance of the model it is replacing. It must also meet the applicable national, state and regional policies, procedures and standards.

The theoretical framework underpinning the development of this model was “demand led access”. Demand led access considers a consumer centric view of care provision and using data on current demand. System performance is then monitored against consumer satisfaction to drive continuous improvement.

The impetus for service reform was consumers’ concerns regarding access and entry. Consideration of the flow-on impact of improved access and entry identified the need for a comprehensive new model to improve care across the entire client journey.

Without whole of system reform MMH&CADS would become overwhelmed resulting in increased wait times and/or poor treatment outcomes.

The timeline below (Figure 2) outlines the key points of development for this Model of Service. There has been a strong focus on collaboration with consumers, carers, staff and external and internal service providers; through formal review processes, face to face forums, surveys and ad hoc feedback.

Implementation of the new model of service has commenced., with preliminary work designed to support the “go live” process. Different aspects of the new model will go live in a phased approach starting with Geraldton in November 2018, and other districts to follow early in 2019. There will be 3, 6 and 12 monthly assessments and reviews completed with the final evaluation due June 2020.

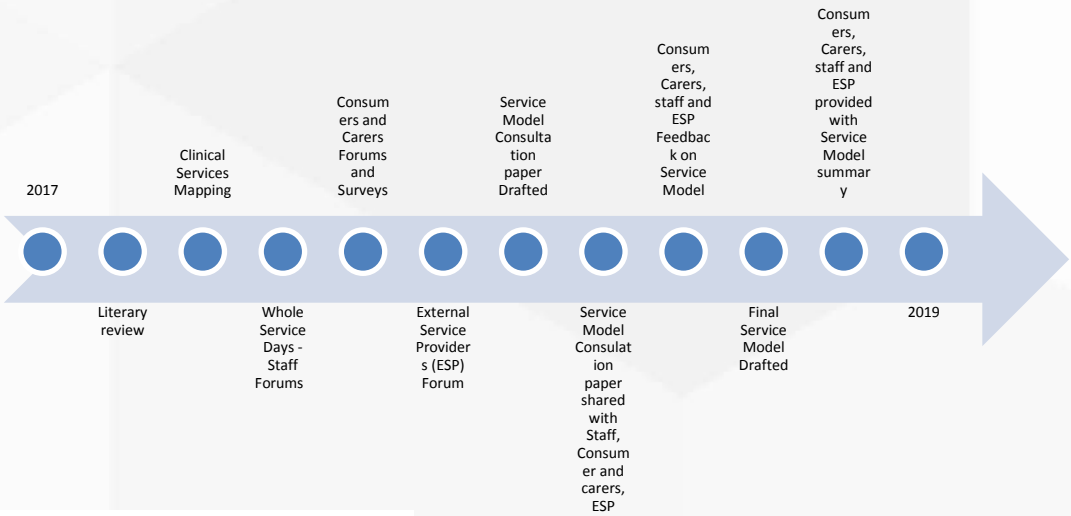
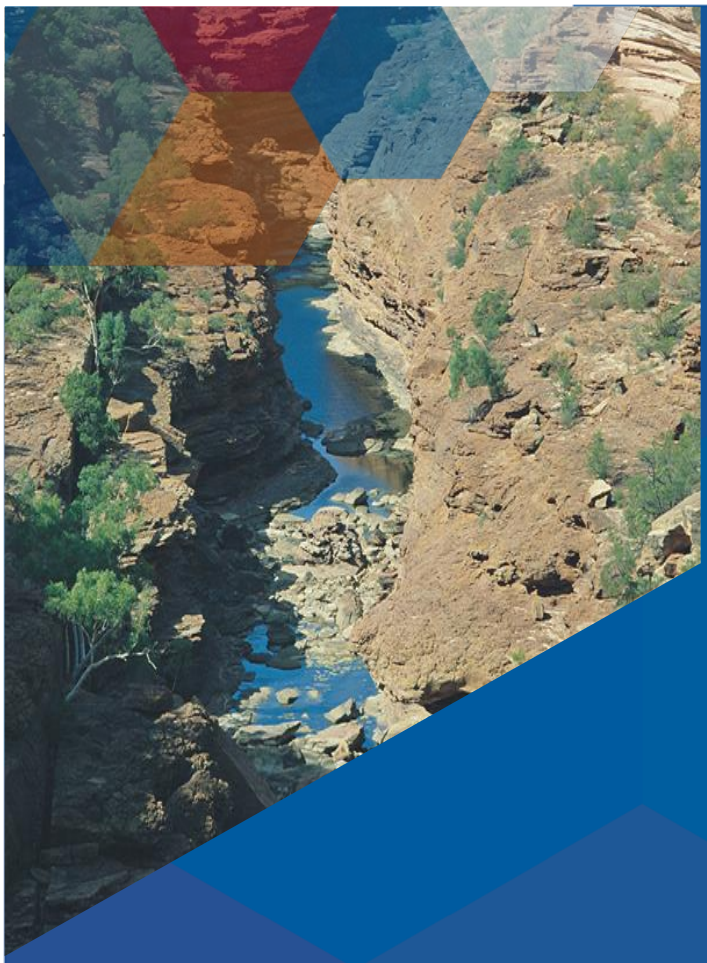


Figure 2 – Model Implementation Timeline



2 Model of Care

Overview

The Model of Care (page 10) is based on a demand lead access model and is designed to limit the time between referral to the service and consultation with the consumer. The service provided is determined by the needs of the consumers.

The model is designed so that the majority of consumers will receive a face to face consultation with a clinician. A joint plan is developed from that initial meeting regardless of whether they will be continuing with the service. The model is developed around a stepped care approach to match consumers' needs to treatment options.

When a referral is made it is initially triaged to assess the immediate level of need. On that basis, a face to face 'Choice' Consultation is offered to the consumer. The timing of this consultation will vary between 'that day' and 'within two weeks' depending on urgency.

After the initial consultation ('Choice' Consultation) the consumer, along with the clinician makes a decision as to what the next step will be.

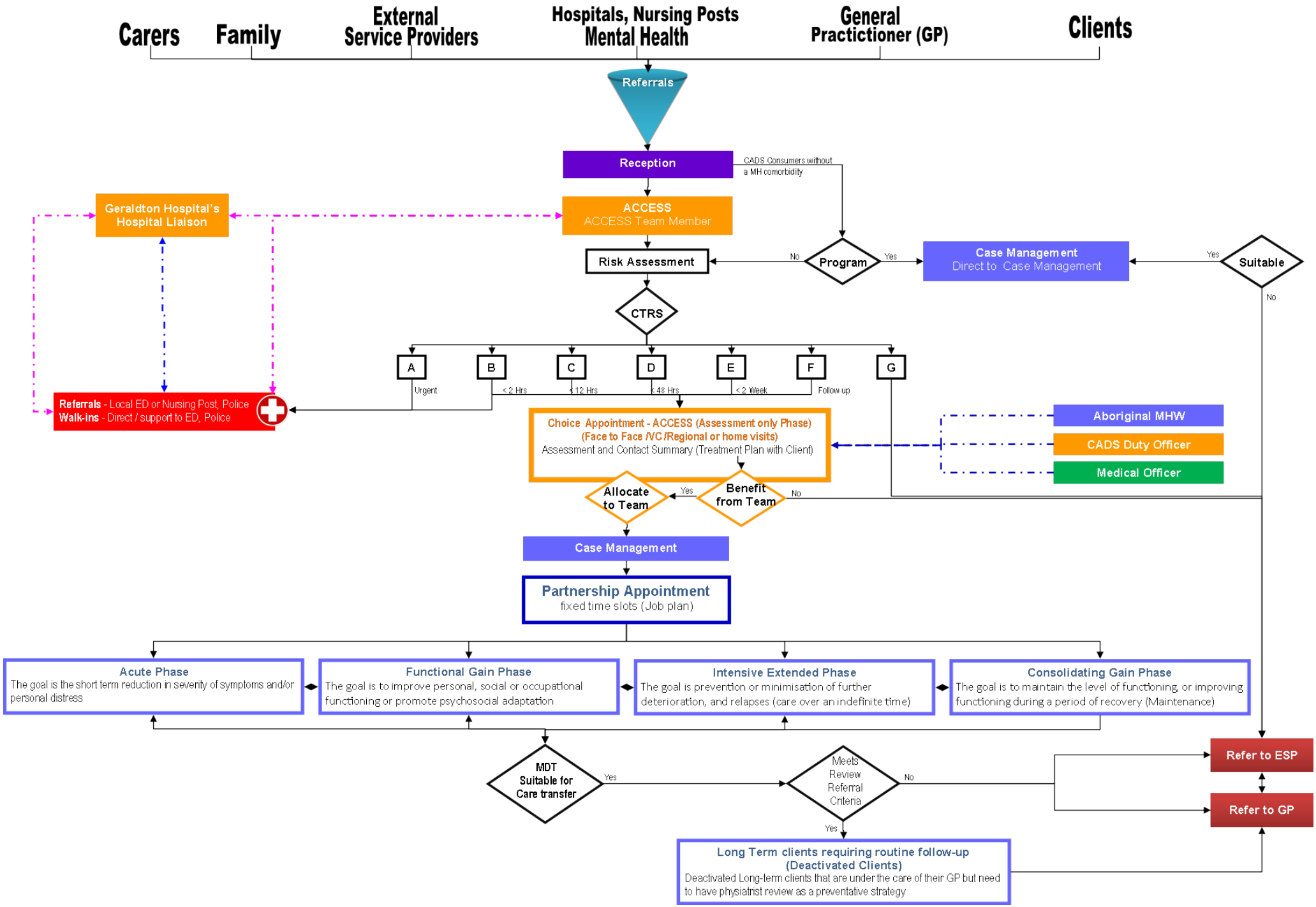
This could include:

- Transfer of care back to the referrer with an action plan, which may include problem formulation, advice and self-care resources
- Referral on to another service/care provider
- Transfer of care to appropriate MMH&CADS team.

Ongoing collaborative care with MMH&CADS is phased to better meet the needs of the consumer. Consumers do not need to pass through all phases or move through them in order. In collaboration with the consumer a decision is made when to cease active therapy and initiate transfer of care.

The Model of Care is based on ease of access, meeting the needs of the consumer and ensuring they receive an appropriate response to their issues in a timely manner. It is inherently a "value add model" where consumers receive treatment for the shortest period of time to effectively meet their needs, prior to their care being transferred.

WACHS – Midwest Mental Health & Community Alcohol & Drug Service (MMH&CADS) Model



Access to the service

Access and referral were identified by consumers and stakeholders as areas for improvement. To improve this MMH&CADS will have streamlined internal systems including:

- The development of a single referral form that is available electronically.
- New IT equipment and infrastructure to facilitate the effective transfer of information.
- Development of clear processes and standards to improve access and entry.
- Multiple phone and fax numbers will be replaced where possible with a single phone, fax and email.
- Systems that support correspondence being directed to the most appropriate team.

All referrals will be accepted with the understanding and consent of the consumer unless risk issues indicate otherwise.

Triage

In the new model triage will significantly reduce the time frame between receipt of referral and first contact with a clinician (choice appointment). Referrals are to be actioned on the same business day as they are received. The goal of triage in in this model is to quickly establish the triage rating and then coordinate a choice appointment. In the majority of cases tirage will be a very quick process

The Crisis Triage Rating Scale (CTRS) is a brief rating scale that will be used to prioritise referrals according to urgency of need ensuring the consumer gets an effective and timely response.

The CTRS categories are:

- Category A: Extreme Urgency ⇨ Immediate response requiring Police / Ambulance or Other Service (e.g. overdose, siege, imminent violence).
- Category B: High Urgency ⇨ See within 2 hours / present to Psychiatric Emergency Service or Emergency Department in General Hospital (e.g. acute suicidality, threatening violence, acute severe non-recurrent stress). ACCESS team involvement dependant on circumstances.
- Category C: Medium Urgency ⇨See within 12 hours (e.g. distressed, suicidal ideation of moderate to severe nature, disturbed behaviour).
- Category D: Low Urgency ⇨ See within 48 hours (e.g. moderate distress has some supports in place but situation becoming more tenuous).
- Category E: Non Urgent ⇨ See within 2 weeks.
- Category F: Requires further triage contact / follow up.
- Category G: No further action required.

‘Choice’ Consultation

A ‘Choice’ Consultation is the first face to face contact offered to the consumer after triage. The ‘Choice’ Consultation provides consumers with as much choice as possible when working together on issues that matter to them. It is collaborative, client centred, recovery orientated and respectful. The ‘Choice’ Consultation may be offered in person, via videoconference, at the clinic, in the consumer’s home or other community based venues. Consumers will be encouraged to invite carers, family and/or other stakeholders to these sessions.

The aims of the ‘Choice’ Consultation will be to:

- Complete initial biopsychosocial needs assessment
- Consider risk and safety of the consumer
- Clarify consumers’ presenting MH / CADS issue
- Clarify consumers’ goals for mental health and general wellbeing
- Ensure consumer is informed of their rights and responsibilities and complete necessary consent and demographic documentation
- Facilitate an exploration of what consumer can do to reach their goals and assess their capacity to engage in self-help strategies
- Offer expert advice and suggestions based on current best practice and available resources
- Enable the consumer to make an informed choice about what services they want or may need
- Explain services that MMH&CADS offer and explore whether MMH&CADS or other agencies are best placed to offer further support
- Document formulation and assessment findings
- Provide a written plan to the consumer at the end of the session.

Involvement of family, carers, and or other service providers in this consultation is highly desirable both in terms of improving the accuracy of the assessment and ensuring that a support plan is developed that is appropriate and meets the identified needs.

Where another service provider is already engaged with the person, there will be a joint plan including the roles of each provider and the type of treatment and/or support to be provided.

If the 'Choice' Consultation determines that an acute admission or more intensive community treatment is required then the team will ensure this occurs.

Intensive follow up and support will be determined by the risk assessment and care plan.

The Advice, Consultation, Collaboration, Entry Support Service Team (ACCESS) Team will work closely with the inpatient services and Mental Health Hospital Consultation Liaison Team (CLT) to reduce hospital stays.

If the 'Choice' Consultation confirms that further support from MMH&CADS is indicated then the client will be invited to participate in a 'Partnership' Consultation.

'Partnership' Consultation

The 'Partnership' consultation is all the work done following the initial 'Choice' consultation. It continues the collaborative work initiated in the 'Choice' Consultation. The number of 'Partnership' Consultations will vary.

The aims of the 'Partnership' Consultation will be to:

- Establish a therapeutic rapport between the consumer and MMH&CADS clinician.
- Consider risk and safety of the consumer
- Clarify who the consumer wishes to involve in their support and safety plan and share necessary information.
- Clarify the consumers goals
- Confirm the consumers commitment to achieving the goals
- Clarify timeframe for achieving their goals and preparing for transfer of care.
- Commencement of an integrated support plan (care plan).
- Provide therapy and support in line with care plan

Therapy and Support

Therapy and support are the clinical methods used by clinicians in collaboration with consumers to address identified issues. The methods are identified in the care plan along with the expected outcomes. Therapy and support will be offered by clinicians within age specific programs:

- Child and Adolescent Mental Health (CAMHS): 0 – 17years
- Adult Mental Health: 18 – 64 years
- Older Adult: 65+ years
- Community Alcohol & Drug Service (CADS): youth, adult and older adults

Care is phased or stepped depending on the identified clinical need. The phase of care is defined by the primary goal of the care plan. It is determined at the commencement of care and reviewed every three months or when there is a significant change in the consumer's presentation.

The phases are:

Acute

- Focuses on short term reduction in severity of symptoms and/or personal distress. This is usually at beginning of care though may also be used if there is a worsening of symptoms.

Functional Gain

- To improve personal, social or occupational functioning or promote psychosocial adaptation. This is where the bulk of the treatment is done once symptom reduction has occurred.

Intensive Extended

- Prevention or minimisation of relapse and moving towards the completion of this period of care. However consumers who are significantly impaired by their mental health or drug and alcohol issues may require a longer period of time in this phase.

Consolidating Gain

- Focuses on maintaining on the consumer's level of functioning. At this time, care is likely to be transferred to another more appropriate provider, often GP.

Assessment only

- obtain information, including collateral information where possible, in order to determine the intervention/treatment needs (Choice Consultation)

Stepped Care

The concept of stepped care is to match the needs of the consumer with the most appropriate level of therapy and support required. Therapeutic and supportive interventions are either “stepped up” or “stepped down” in intensity depending on the needs of the client.

The ‘Choice’ Consultation initially informs the level of therapy and support required (Phase of Care). When a consumer engages in ‘Partnership’ Consultations with MMH&CADS their needs will be further assessed and their phase of care reviewed.

Stepping up or stepping down may involve transfer of care to another agency or service.

Transfer of Care

Continuity of care refers to care over time, often when different health providers are involved at different stages of care. Effective transfer of care is vital to maintaining good continuity of care. In the current model transfer of care happens mainly at two points,

- when some aspect of care is transferred into the service, which is covered in access and entry
- when the care is transferred out of the service to another care provider

The key to effective transfer of care is comprehensive, accurate and timely two-way communication regarding assessment, therapy, support and consumers’ on-going care needs.

Successful transfer of care is facilitated by

- Consumer and their family / carer / guardian engagement
- Clear and timely communication
- Good collaboration between service providers
- Good planning (from ‘Choice’ Consultation and throughout ‘Partnership’ consultations)
- Timely Multidisciplinary reviews and up to date care plans
- Early preparation for transfer of care
- Compliance with national, state and regional policies and legislation

In the current model care can be transferred out of the service at any time depending on the clinical need and in collaboration with consumers. Consumers can then return to the service quickly and smoothly to ensure good continuity of care.

Performance Monitoring and Quality Improvement

Built into the demand led service development model are a set of measures designed to drive quality improvement after implementation, these are:

- The consumer’s perception of whether they have been helped by the service (Patient Reported Outcome Measures)
- How happy the consumer is with the service (Patient Reported Experience Measures)
- Things that research has demonstrated have an impact on consumer satisfaction, e.g. time from referral to first face to face contact
- Measure of clinical effectiveness

The goal is to collect this data in as close to real time as possible. The measures are then used to identify those things that need to be changed. By having access to the data on a monthly if not weekly basis trends can be identified early and addressed in a quick and efficient manner

In Appendix 3 there is a list of the most likely measures that will be used.

3 The Teams

Management Team

The management team will provide strong leadership and support to achieve the vision of developing MMH&CADS as a centre for excellence in MH&CADS service provision.

Management team responsibilities include:

- Logistical, clinical and corporate management
- Safety and Quality management for:
  - Accreditation
  - Clinical Governance
  - Risk Management
  - Consumer Feedback
  - Data management
- Staff Development
- Liaison with key stakeholders

Reception and Administration Team

Key to the success of the new model of service is efficient and effective administrative staff supported by good systems to:

- Welcome consumers and carers
- Effectively direct attendees to the clinic to the most appropriate person or information for their needs.
- Provide effective and secure medical records management.
- Support clinicians to ensure the smooth function of the service.

Advice, Consultation, Collaboration, Entry, Support Service (ACCESS) Team

The ACCESS functions will be completed by clinicians working from within the ACCESS Team and key staff from within the Care teams. Clinicians providing ACCESS function will provide:

- Comprehensive needs assessment in collaboration with consumers, carers and stakeholders
- Collaborative care planning and treatment options
- Specialist mental health advice
- Support and information to other health providers and agencies
- Facilitate access to the most appropriate care providers
- Treat people in the community to reduce preventable hospital presentations

Consultation and Liaison Team (CLT)

The Consultation and Liaison Team (CLT) provides comprehensive mental health assessment, treatment and discharge planning for people presenting or admitted to Geraldton Hospital with mental health conditions, with the aim of improving the recognition and appropriate management of mental health issues and comorbidities. The CLT will continue to be an essential component of the model of service, working closely with the ACCESS team to provide a first point of contact with MMH&CADS.

They CLT will also provide specialist advice to other sites within the Midwest region and support training and development of general hospital staff to improve holistic care of consumers with mental health and/or drug and alcohol issues in the non-ambulant setting.

Aboriginal Mental Health Team

The MMH&CADS Aboriginal Mental Health Team works within the WACHS Aboriginal Mental Health Model of Care which aims to draw together cultural and clinical expertise in delivering services. It embraces the social and emotional well-being concepts in provision of high quality mental health services for Aboriginal people in rural and remote Western Australia.

Aboriginal Mental Health Workers are part of the multidisciplinary team and are fully integrated into the regional service. Their role is to strengthen the cultural competence of MMH&CADS and facilitate access and advocate for Aboriginal people, this includes:

- Working as secondary case managers or key workers for Aboriginal clients of the service,
- Working in close conjunction with the Community Mental Health Professionals to support
  - Culturally secure practice
  - Working with the ACCESS Team at the first point of contact and assessment

- Provide specialised support to regional sites via tele-health for triage and assessment.

Child and Adolescent Mental Health Services (CAMHS) Team

CAMHS is a multi-disciplinary team that provides mental health programs to infants, children and young people aged 0 – 17 years of age and their families. CAMHS clinicians work with a holistic approach, working with schools, extended families and statutory bodies. The CAMHS team will provide:

- Assessment, therapy and support
- Support training to other professionals and carers
- Engagement of Aboriginal Mental Health Team

There has also been uplift in funding for the CAMHS team that will result in changes to clinical service provision.

Adult Team

The Adult Team is a multi-disciplinary team providing care to people aged between 18 to 64 (18 to 54 for consumers of Aboriginal descent) with a moderate to severe mental illness.

The Adult Team work with consumers, carers, families, Government and other non-governmental organizations to identify and address needs and coordinate care to assist in their recovery.

The Adult Team will provide:

- Assessment, therapy and support
- Shared care with General Practitioners and other support services in providing holistic care
- Supporting education for consumers, carers, and other support services in recognizing early warning signs of mental illness

Older Adult Team

The Older Adult team works with people over the age of 65 (over the age of 55 for individuals of Aboriginal descent) with moderate to severe mental health issues. They also provide care for people with psychiatric or severe behavioural difficulties associated with organic disorders.

The Older Adult team will provide

- Assessment, therapy and support
- Support training for other professionals and carers

Community Alcohol and Drug Service (CADS) Team

The CADS team will provide initial assessment, ongoing care, treatment and support to youth, adults and older adults presenting with drug and alcohol issues.

The CADS team will provide:

- Joint consultation ('Choice' Consultation) for consumers presenting with comorbid mental health and drug and alcohol issues
- Assessment, therapy and support
- Support and information for carers and family members of those with drug and alcohol issues
- Early Intervention, Education and Prevention
- A range of diversion and pharmacotherapy programs
- Needle Syringe Exchange Program (NSEP)

The new model will enable CADS to fully merge with the mental health team and become one service. This integration will result in improved channels of communication and sharing of resources and knowledge.

4 Implementation and Outcomes

Implementation

Implementation of the new model will occur over an 18 to 24 month period commencing with initial changes to systems, teams and procedures in Geraldton in preparation for a 'go live' in November 2018.

The implementation plan has six priority areas:

- Workforce
- Service Delivery
- Communication, Consultation and Collaboration
- Infrastructure
- Information Communication Technology
- Safety and Quality, Governance and Key Performance Indicators

Consumers and carers will continue to participate in the ongoing development of the service through a variety of methods to ensure collaboration and co-production.

At the end of the implementation period a final review is to be completed in 2020. At that stage the reform should be completed and the changes established should constitute normal business. Key Performance Indicators that monitor performance will allow the service to continue its program of continuous quality improvement into the future.

The implementation plan is detailed in a separate document.

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Expected outcomes

The expect outcomes from this reform include:

- An increase in reported positive consumer experience
- Improved clinical outcomes
- Reduction in clinical incidences
- Reduction in hospital presentations
- Improved collaboration within the MMH&CADS teams
- Improved relationship with external stakeholders

Resources

Australian National Standards

Fifth National Mental Health Plan 2017

Nation Mental Health Standards 2010

National Drug Strategy 2017-2026

National Alcohol Strategy 2018-2026

National Safety & Quality Health Service Standards - 2nd Edition

Western Australian Mental Health

Mental Health Act 2014

Mental Health 2020 Strategic Policy

WA Mental Health, Alcohol and other Drug Service Plan 2015-2025

Office of Chief Psychiatrist Standards and Guidelines

State-wide Standardised Clinical Documentation Implementation

Western Australian Country Health Service (WACHS)

WACHS Strategic Directions 2015 – 2018

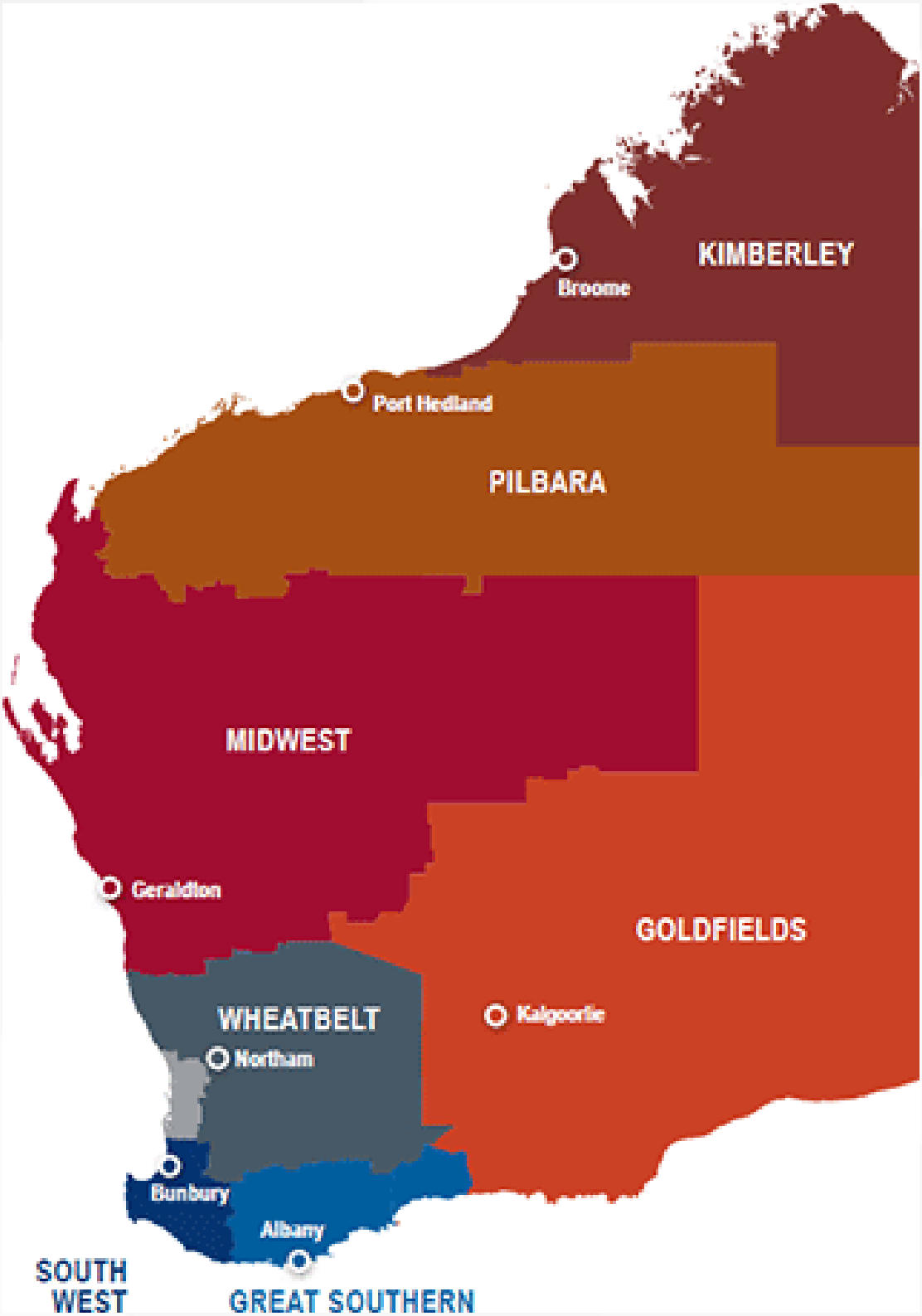
WACHS Safety and Quality Priorities 2018 - 2019

WACHS Aboriginal Mental Health Model of Care

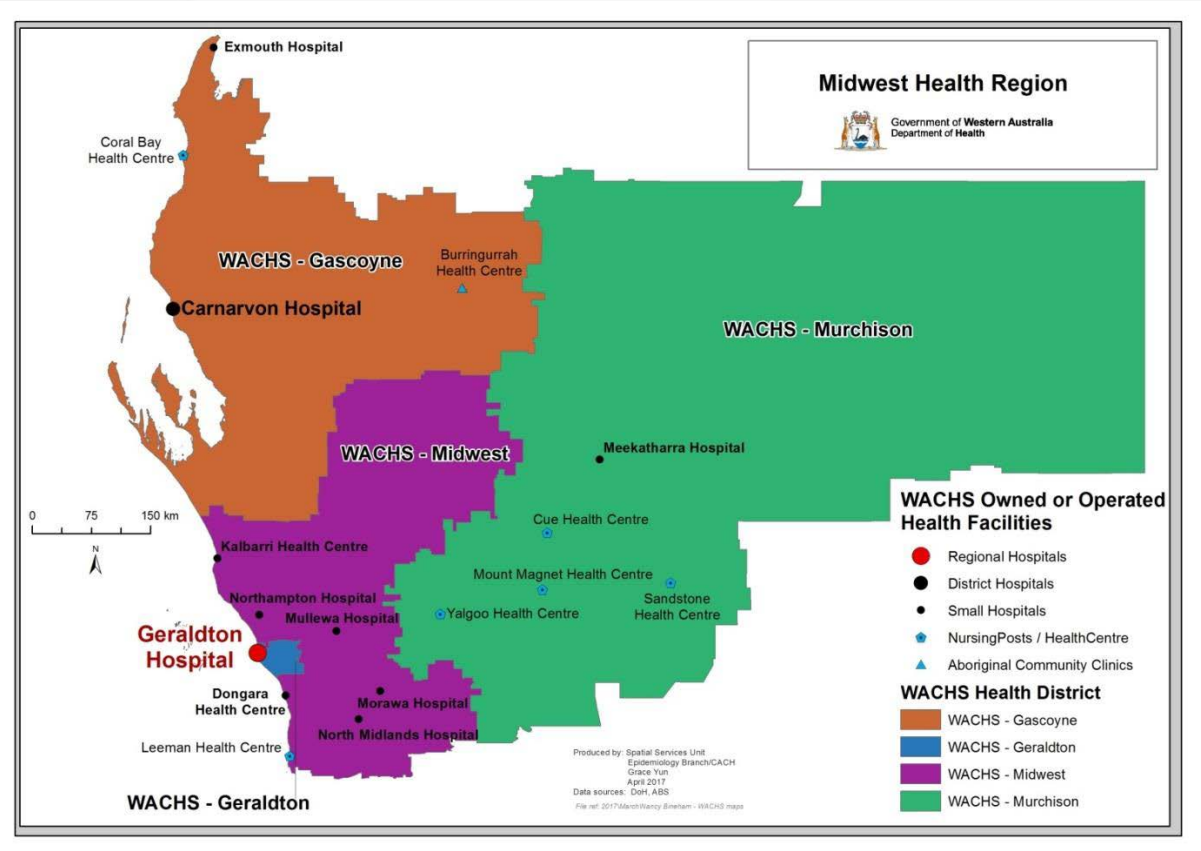
Regional Health Profile - Midwest

5 Appendix

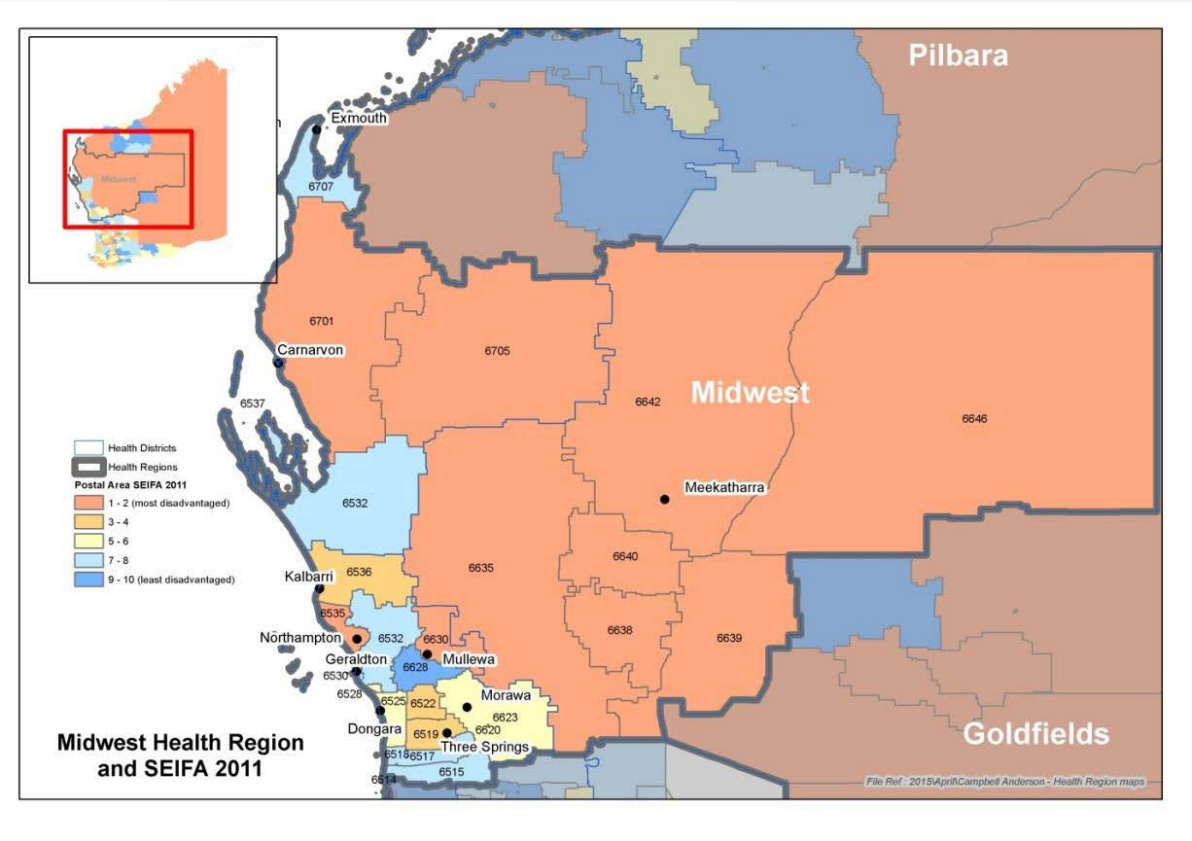
Appendix 1: Regional Maps



Map of Western Australia showing Health Regions



Map of Midwest showing Health Districts and WACHS Health Facilities



Map of Midwest Socio-Economic Indexes for Areas distribution 2011

Appendix 2: Evaluation Measures

Below are the likely measures used to measure service performance.

Clinical Outcomes, Safety & Quality Measures

- National Outcomes and Casemix Collection (NOCCS)
- Alcohol Use Disorders Identification Test – Consumption (Audit – C), Alcohol Use Disorders Identification Test – Drugs (Audit – D)
- Beck Depression Inventory (BDI), Depression Anxiety Stress Scale (DASS), Hospital Anxiety and Depression Scale (HADS)
- Clinical Incidence Management System (CIMS)

Patient Reported Outcome Measures (PROMS)

- Strengths and Difficulties Questionnaire (SDQ) / Kessler Psychological Distress Scale (K10)
- Management Plans
- Meeting CTRS (Crisis Triage Rating Scale) time
- Clinical Incidence Management System (CIMS)

Patient Reported Experience Measures (PREMS)

- Your Experience Survey (YES) / CAMHS Experience Survey Questionnaire (ESQ)
- Compliments and Complaints
- Focus Groups

Efficiency & Flow Measures

- Time From Referral to 1st RART Face-to-Face Consultation
- Time From 1st RART Face-to-Face Consultation to Activation
- Time From Activation to Deactivation
- Number of Activations / Deactivations