

Counties Manukau District Health Board Mental Health Services

Core Adult Services Project Summary of Outcomes

April 2006

1.0 Background Information

In 2003 Counties Manukau District Health Board (CMDHB) conducted a series of consultation meetings with key stakeholders in order to help identify the issues facing the mental health sector in Counties Manukau. As a result of this process a number of service development projects and initiatives were put in place. The primary objective of all of these initiatives has been to develop effective recovery based mental health services aimed at improving the lives and opportunities of people with a mental illness.

The consultation process identified a number of key issues relating to the CMDHB-provided adult mental health services (Appendix I). In order to address these issues a multi-faceted service development project was commissioned by the Manager Mental Health Development, in partnership with the Programme Manager for Mental Health Planning and Funding and the General Manager and Clinical Director of CMDHB Mental Health Services. This project became known as the Core Adult Services Project (CASP).

The CASP began in late 2003 and continued through until the end of 2005. Whilst the CASP has now concluded, work from this project has resulted in the development of an ongoing programme of service development initiatives which will be implemented within the CMDHB-provided adult mental health services in 2006. This work is in addition to the ongoing programme of service improvement initiatives and projects which have been initiated within the provider arm.

The purpose of this paper is to provide an overview of the CASP and its outcomes. It includes:

- § an overview of the project structure and objectives
- § a summary of the outcomes
- § an overview of ongoing work to be initiated in 2006

2.0 Overview of Structure and Objectives of the Core Adult Services Project

One of the key challenges in developing the initial project plan and structure was the broad range of complex inter-related issues that the project aimed to address. Because of this the CASP was designed to have a series of distinct but closely related work-streams. Whilst each work-stream had clearly defined objectives there were a number of dependencies between them. Consequently a project management group (PMG) was established to oversee the project and to ensure co-ordination and consistency in the overall outcomes of the project.

Initially the work-streams were identified as:

- § Role and Function
- § Triage
- § Acute Responsiveness

A copy of the objectives of each work-stream is included in Appendix II.

The intention was that for each work-stream, the project would provide the process for identifying solutions to the key issues facing the DHB mental health services and implementing and evaluating the agreed solutions. Consequently the project was conducted in two phases:

- § Phase I: Solution Identification
- § Phase II: Implementation Planning

The project sponsors were eager to ensure strong stakeholder representation in the project decision making processes. As a result the project was structured to include a number of working groups which were responsible for making recommendations to the PMG. The working groups were largely made up of mental health services staff with some consumer and family member representation. In addition to this a Reference Group was established for Phase I of the project. The reference group had an advisory role and consisted of a broader range of stakeholders. A copy of the project structure is included in Appendix III.

3.0 Progress To Date

3.1 Overview of Project Implementation Process

Because of the number of dependencies between the work-streams it was decided that work on the “Role and Function” and “Triage” work-streams would commence in advance of the work on the “Acute Responsiveness” work-stream. As the project progressed it became increasingly evident that it was not possible to separate out issues in relation to “acute responsiveness” and hence a decision was made not to institute a separate “acute responsiveness” work-stream but rather to embed these issues within the two existing work-streams.

The working group process proved to be a successful model for ensuring that solutions were not imposed in a “top-down approach”. Of note all of the recommendations from the various working groups were subsequently ratified by the Project Management Group. Key to the success of this process was ensuring that the working groups were well-briefed and that their roles and responsibilities were clearly articulated from the outset. Hence working groups were provided with a comprehensive package of background information prior to beginning to address the issues at hand. This included:

- § A review of relevant national and international literature on the issues to be addressed
- § Where minimal literature could be found a review of current practice across other DHB mental health services was conducted (e.g. in relation to triage processes)
- § Specification of the key questions to be addressed by the working group
- § Clear identification of the roles and responsibilities of the working group and the process for addressing any conflict that may arise either within the working group or between the working group and the PMG.
- § Identification of issues that the PMG considered to be “not negotiable”

At the end of phase I (solution identification) working group membership and structure was reviewed and revised. As a result the number of working groups increased but the size of the groups decreased. This was largely due to the detailed nature of the implementation planning process required for phase II. It also provided an opportunity for a wider group of people to become involved in the working group process, whilst ensuring that there was some consistency in membership between phases I and II.

3.2 Summary of Outcomes

The first outcome to result from the CASP was the decision to move from having five community teams operating from two sites, to four community mental health centres (CMHCs) each located within the geographical area that they serve, and staffed according to size of population served and level of need in the local community. This decision was made based on feedback received during the CASP consultation and a subsequent analysis of demographic data in relation to the Counties Manukau community.

This decision was made prior to the establishment of the working groups. As a result it was decided that the CASP working groups would focus primarily on issues in relation to the mainstream adult mental health services provided from these CMHCs. The intention was that the CASP outcomes would then be reviewed in terms of their applicability to Maori and Pacific services. Where appropriate the Maori and Pacific services would be expected to follow a similar model to the mainstream services, unless the agreed model was not relevant or appropriate for a culturally specific service.

Subsequently a separate process aimed at the development of a Maori CMHC has been commissioned. This process which is still underway has used the CASP findings in relation to CMHC structures, roles and functions as the basis for its decision making.

The key outcomes from the CASP work-streams are summarised below:

3.2.1 CMHC Structure and Functions

One of the first issues addressed by the CASP was to agree which functions should fall into each of the following categories:

- § Generic function of the CMHC
- § Dedicated function within the CMHC
- § Function provided by a separate team outside the CMHC

As a result of this process it was agreed that:

- § Intensive Clinical Services should be provided by a separate but closely aligned team.
- § Maternal Mental Health, DBT, and Crisis service delivery should be dedicated functions within the overall CMHC team (staff with dedicated roles embedded in the CMHC team).
- § Additional FTEs would be added to the crisis function and that the crisis function should follow a crisis resolution model rather than a crisis assessment model.
- § The ability to provide services to people with a dual mental health and substance abuse problem should be a core competency of all CMHC staff (Dual Diagnosis services should not be separated from the Core CMHC function). In order for this to be implemented a significant programme of staff development would be required and staff would need access to some specialist dual diagnosis expertise.

Subsequently operational guidelines have been developed for the following functions:

- § Crisis function¹
- § Maternal Mental Health²
- § DBT³

Core competencies for staff working in these roles have also been developed and agreed.

3.2.2 CMHC Core Role and Function

In addition to developing operational guidelines for the dedicated functions within the CMHCs a number of decisions were made in relation to the core role and function of these services. A summary of these decisions is outlined below with more detailed information included in Appendix IV.

- § The core roles and responsibilities of DHB provided adult mental health services have been agreed and documented. This has been done in relation to services provided to :
 - people with moderate to severe mental illness who when well do not have a need for formalised support to live a full life in the community AND
 - people with severe mental illness who have ongoing support (rehabilitation) needs even when relatively well.
- § The models of service delivery to be provided by the CMHCs have been agreed and documented. These models include:
 - GP Liaison
 - Clinical Case Management
 - Clinic Based Services
 - Crisis Services

¹ CMDHB adult mental health services Crisis Function Operational Guideline, January 2006

² CMDHB adult mental health services Maternal Mental Health Operational Guideline October 2005

³ CMDHB adult mental health services DBT operational Guideline October 2005

- § A consistent approach to a range of clinical processes within the CMHCs has been agreed including
 - Allocation of referrals
 - Initial assessments
 - Care Planning
 - Clinical Review Processes
 - Discharge
- § Guidelines for CMHC staff regarding communication with GPs have been developed
- § The overarching principles to guide the interface between inpatient and community services have been agreed
- § Core competencies for key workers within the CMHCs have been developed and agreed. A stock-take of current training availability regionally and nationally has been completed and the competencies have been mapped to the available training.

3.2.3 Triage

- § Entry criteria for Core Adult Services have been agreed and documented
- § A model for triage of new referrals within usual business hours has been agreed and implemented. An operational guideline outlining this process has been developed and agreed⁴.
- § Guidelines for GPs regarding referral processes and pathways for adult mental health services have been developed and distributed to all GPs in the local area.

4.0 Work To Be Completed.

Whilst the CASP objectives have been met in relation to solution development and implementation planning, the size of the project and enormous volume of work that has resulted from it has meant that in some instances, the implementation of the agreed solutions has been slower than expected. However there is a clear commitment to ensure that all of the agreed solutions are implemented over the next few months. . Plans for full implementation of the CASP outcomes are summarised in section 4.1 below.

Furthermore as a result of the project other related service development needs that were not part of the original brief of the project have been identified and plans for addressing these are now underway. A summary of these plans is included in section 4.2 below. This work will be led within the provider arm and will form part of a wider ongoing programme of service improvement.

Finally in order to assess whether or not the issues identified by stakeholders during the initial consultation process have been addressed an evaluation programme is currently under way. A summary of this programme is included in section 4.3.

⁴ CMDHB Adult Mental Health Services, Triage Operational Guideline, August 2005.

4.1 CASP Implementation Work Yet To Be Completed

4.1.1 CMHC Structure and Functions

a) Implementation of DBT Operational Guideline

The operational guideline for the delivery of DBT within the CMHCs agreed as part of the CASP is yet to be implemented. Work on implementation of this model of service delivery is currently under-way. A DBT coordinator has been appointed and expressions of interest for the DBT clinician positions have been sought.

Responsibility: Service Manger, Core Adult Services

b) Implementation of Dual Diagnosis Model of Service Delivery

A draft collaboration agreement between CMDHB and WDHB regional dual diagnosis service has been developed but is yet to be ratified by the parties. This agreement outlines plans for training programmes for CMDHB clinical staff and for the provision of consultation liaison services by the regional services to the CMDHB adult mental health services.

Specific project management time has been assigned to this and work is expected to commence in early 2006.

Responsibility : General Manger/Clinical Director

c) Model of Service Delivery for Early Psychosis Intervention (EPI)

It was agreed early in the CASP that work on developing and implementing a model of service delivery for people experiencing a first episode of psychosis should be removed from this project because these services do not sit entirely within the CMDHB adult mental health services which were the focus of the CASP.

Work is currently underway within the CMDHB provided services to ensure a consistent and effective model of EPI service delivery across the adult and child and youth services. A coordinator has been appointed to work across the various DHB provided EPI teams in order to develop a consistent approach. Further work is required to ensure a consistent and effective approach across the DHB and NGO provided EPI services.

Additional funding for 4 FTE EPI clinicians has been made available for the 2006/07 year.

Responsibility: General Manager/Clinical Director
Programme Manager

4.1.2 CMHC Core Role and Function

a) CMHC Core Role and Function Project

Decisions regarding CMHC functions such as models of service delivery, clinical processes and guidelines for communication with GPs are yet to be fully implemented. A project plan for implementation of this work has been developed and agreed and will be implemented over the next 6-12 months.

Responsibility: General Manager /Clinical Director

b) Core Competencies

The core competencies developed during the CASP are yet to be incorporated into the staff performance/staff development programmes. This includes ensuring that the competencies are incorporated into performance appraisal and into professional development plans for staff. This will form part of a workforce development project initiated within the provider arm.

Responsibility: General Manager/Clinical Director

c) CMHC/Tiaho Mai Interface

Implementation of work regarding improving the integration between inpatient and community services is yet to be fully implemented. This work is ongoing within the provider arm services.

Responsibility: General Manager/Clinical Director

4.1.3 Triage

a) After Hours Triage

The northern region DHBs have agreed in principle to implementing a regional after-hours service for the triage of calls to mental health services. This service will be based upon the "Mental Health Line" concept which operates in some other parts of the country. Work on implementation planning is expected to commence by April 2006. A final decision as to whether the Mental Health Line is a viable and effective model of after hours triage in Counties Manukau is expected in June 2006 at the completion of the implementation planning exercise.

Responsibility: Programme Manager Mental Health
General Manager/Clinical Director
Manager Mental Health Development

4.2 Other Planned Work

a) **Acute Services Project**

As a result of the CASP and other work both within the provider arm and at a planning and funding level, several service developments in relation to acute services have been implemented or are planned.

These include:

- § A review of crisis respite services
- § Planning and implementation of a Home Based Treatment function within the CMHCs
- § Additional funding allocated for alternative to inpatient care

It has been agreed that in order to achieve the best possible outcomes for service users a planned approach to the development of acute services is needed. Hence a project aimed at identifying the spectrum of acute services needed to meet the needs of mental health service users in Counties Manukau is currently under development. It is expected that the outcomes of this project will inform decision making regarding the range of services needed, how they work together and priority areas for the establishment of new services and re-development of existing services.

Project Sponsors: Manager Mental Health Development
 Programme Manager, Mental Health
 General Manager/Clinical Director

b) **Physical Health Project**

A project aimed at considering the physical health needs of people with serious ongoing mental health problems is currently underway. This project aims to address issues in relation to monitoring and addressing potential metabolic complications of anti-psychotic medications and ensuring mental health service users are actively engaged with primary health-care.

Project Sponsors: Programme Manager, Mental Health
 General Manager/Clinical Director

c) **Tiaho Mai Reconfiguration**

A proposal to renovate and reconfigure Tiaho Mai has been developed and is currently awaiting MOH approval. The aim of the reconfiguration is to:

- § Enable inpatient and community services to be fully aligned
- § Increase flexibility to meet needs of high acuity service users while minimising restraint and seclusion
- § Address a backlog of maintenance issues
- § Improve the therapeutic milieu of the unit

Pending MOH approval a project plan will be developed aimed at designing and implementing the necessary changes. This will include changes to the physical structure of the building and the necessary reconfiguration of models of service delivery.

Responsibility General Manager/Clinical Director

d) DHB NGO Interface

Work already completed in this area includes the development of a Community Living Services Collaboration Agreement and the commissioning of a project by the DHB/NGO collaborative group aimed at improving the interface between CSW, ISW and DHB services.

A collaborative group of DHB and NGO service providers will lead a range of service improvement initiatives including work on improving the interface between services. This work will be undertaken in conjunction with any funding and planning initiatives regarding the future direction of CSW and ISW.

Responsibility	Programme Manager Mental Health General Manager/Clinical Director
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e) CMHC Roles

Work within the CASP identified questions in relation to clinician roles within the CMHCs. In particular whether clinicians within CMHCs should be employed in generic roles, discipline specific roles or a combination of both of these. Preliminary work undertaken during the CASP indicated that many of the core competencies were generic with some few discipline specific competencies identified, however further review of this issue is required. As yet it has not been decided whether further work on this issue will be implemented in 2006 or whether this will be deferred until after the implementation of the CMHC core role and function project.

4.3 Evaluation

The CASP was a large multi-faceted project which was initiated at the same time as a number of other service development projects within the mental health sector in Counties Manukau. Because of the complex inter-dependencies between the different work-streams within the CASP and between the CASP and other sector developments it is not possible to evaluate the outcomes of any of these initiatives in isolation. As a result it has been decided to initiate a sector wide evaluation project which reviews progress across a number of domains over the next 1-2 years.

Issues identified in the initial CASP consultation process were used to guide decisions regarding what types of information would be collected and reviewed. Baseline information has been gathered from a sample of service users, family members and mental health service staff and managers. In addition to this a postal survey of Counties Manukau GPs and a clinical file audit within the CMDHB adult services have been conducted. The results of this initial information gathering process are currently being analysed.

The process will be repeated in 12-18 months time and the results compared with those from the initial data gathering in order to assess the degree to which progress has been made.

APPENDIX I:

Summary of key issues facing the CMDHB provided mental health services, as identified during 2003 consultation process led by Manager Mental Health Development.

Fragmentation

Lack of integration was identified at all levels including between:

- Ø Primary Health Care and Core Community Teams
- Ø Core Community Teams and Inpatient Services
- Ø Core Community Teams and Specialist Services/Teams
- Ø DHB and NGO Services

Poor Alignment

An issue that was closely related to the problems with fragmentation was that of poor alignment between services. Most notably there was concern regarding alignment between CSW teams and Core Community Teams which result in community support workers having to relate to a large number of key workers from a range of different teams and key workers having to relate to a range of different CSW services and workers. Similarly there were concerns expressed regarding the lack of alignment between some of the specialist community services and the core community teams.

Workforce Capacity

There was widespread acknowledgement that the mental health workforce did not have access to the type of training and tools necessary to do their job in the current environment.

Configuration And Role Of Core Community Teams

A range of issues regarding the configuration and role of core community teams were identified most notably the lack of clarity/consistency in the role of the core community teams

Acute Responsiveness

There was widespread concern regarding the “acute responsiveness” of the mental health system. These included:

- the inability of key workers to increase the intensity of services provided when a service user develops “early warning signs” of illness relapse
- concerns regarding the ability of some services to respond rapidly during crises
- A lack of options (alternatives to hospitalisation) for people who are acutely unwell or becoming unwell
- Lack of flexible and appropriate crisis respite options

Role and Function

The Role and Function work-stream focussed on addressing issues that had been identified regarding a lack of clarity and consistency in the roles of the core community mental health teams. This included:

- i) Agree and Define the core role and function of the core community teams in relation to people with:
 - a) Serious mental illness with high support needs⁵.
 - b) Moderate to severe mental illness (but who do not have high support needs).
- ii) Agree the approach to service delivery (separate team or people working with a specific focus integrated within core community teams⁶) for the following groups. People who are:
 - Ø experiencing a first episode of psychosis
 - Ø diagnosed with a borderline personality disorder (BPD)
 - Ø pregnant or post partum
 - Ø in crisis
 - Ø diagnosed with a dual Mental Health and substance misuse problem
 - Ø requiring intensive clinical services (difficulty engaging with services, itinerant, CJ involvement, poor response to medication)
- iii) Develop and agree mechanisms for ensuring alignment of separate teams and core community teams (where this is the agreed model)
- iv) Develop and agree mechanisms for ensuring peer support, consistency and ongoing skill development for people working with a specialist focus within an integrated model (where this is the agreed model)
- v) Agree on the most appropriate approach for ensuring an effective interface between core community teams and acute inpatient services (greater alignment or integrated model).
- vi) Develop a workforce development (WFD) plan in line with proposed model(s) of service delivery. This plan will include:
 - Identification of required workforce competencies to meet the agreed roles and functions of each of the service types
 - A summary of current workforce capabilities
 - Identification of training needs to meet any gap between required competencies and current capabilities/capacity
 - A detailed recruitment and retention plan
 - Plans to ensure an ongoing focus on workforce development
- viii) Develop an implementation plan (including evaluation framework) in line with the agreed approach to service delivery.

⁵ This is the group of people who require rehabilitation services in order to attain recovery and achieve a life in the community.

⁶The intent here is to decide on whether or not, (for each of these groups of people), there should be a separate team that is dedicated to the delivery of services that meet their specific needs **or** whether there should be clinicians working within each of the core community teams that have a specific focus on each of these groups.

Triage

This component of project focussed on addressing issues regarding pathways into the DHB mental health services, including:

- i) Agree and define the eligibility criteria for all Adult Mental Health Services
- ii) Agree and describe referral/client pathways into the Adult Mental Health Services.
- iii) Develop a WFD plan in line with the agreed model of triage. This plan will include:
 - Identification of required workforce competencies to meet the agreed model of triage
 - A summary of current workforce capabilities
 - Identification of training needs to meet any gap between required competencies and current capabilities/capacity
 - A detailed recruitment and retention plan
 - Plans to ensure an ongoing focus on workforce development
- iv) Develop an implementation plan (including evaluation framework) in line with agreed approach to triage.

Acute Responsiveness

This component of the project was intended to address issues in relation to improving the acute responsiveness⁷ of the DHB mental health services including:

- i) Develop procedures and practices that have the capacity to enhance the acute responsiveness of existing services and ensure that they provide timely and effective treatment and prevent further deterioration.
- ii) Develop a WFD plan to support implementation of practices agreed to improve acute responsiveness. This plan will include:
 - Identification of required workforce competencies to meet the agreed approach to service delivery
 - A summary of current workforce capabilities
 - Identification of training needs to meet any gap between required competencies and current capabilities/capacity
 - A detailed recruitment and retention plan
 - Plans to ensure an ongoing focus on workforce development
- iii) Develop an implementation plan (including evaluation framework) in line with agreed approach to enhancing acute responsiveness.

⁷ Acute responsiveness refers to the ability of services to respond promptly and effectively to the needs of service users who are beginning to become or unwell or who have become acutely unwell.

APPENDIX III

Core Adult Services Project – Project Structure

Project Sponsors	Manager, Mental Health Development
	General Manager, Mental Health & Intermediary Care
	Clinical Director Mental Health
	Mental Health Programmes Manager
	Kaumatua
Project Management Group	Project Manager
	Clinical Head, Core Adult Services
	Manager, Core Adult Services
	Clinical Head, Maori Mental Health
	Service Manager, Maori Mental Health
	Project Manager, Pacific Mental Health
	Senior Consumer Advisor
	2 Sponsor identified leaders
Reference Group	DHB Consumer Advisors (1 representative)
	Consumer Strategy Group (1-2 representatives)
	Supporting Families (2 representatives)
	NGO (2-4 representatives) ⁸
	DHB Professional Leaders
	Adult Services Team Leaders
	Regional Funder and Planner (1 representative)
	PSA (1 representative)
	DHB Adult services staff (2 representatives)
	ReAMS (1 representative)
	GP Liaison (1 representative)
Working Groups	<p>Working groups for each of the work-streams. Working group membership varied between each of the working groups however in general membership included::</p> <ul style="list-style-type: none"> • Clinicians • Managers/team leaders • Consumers • Other relevant project workers

⁸ 1-2 mainstream representatives. 1 Maori representative. 1 Pacific representative.

APPENDIX IV

Summary of Outcomes: CMHC Roles

The working group were asked to make recommendations regarding the role and function of the CMHCs in relation to:

- Those people with moderate to severe mental illness who when well do not have a need for formalised support to live a full life in the community
- Those people with severe mental illness who have ongoing support needs even when relatively well.

In considering the answers to these questions the working group were asked to decide:

- What is it that **only** DHB clinical services can do?
- What is it that with some additional training and back up support other service providers (primary care, NGO mental health service providers, or peer support services) could do?

The working group recommended:

For those people with moderate to severe mental illness who when well do not have a need for formalised support to live a full life in the community:

- ✓ Assessment, planning and treatment functions (including service coordination) can be carried out by both DHB secondary services and PHOs, with the general rule being that the greater the complexity of the problem the more that DHB secondary services should be involved.
- ✓ Greater flexibility in the relation between primary and secondary services is required including options such as:
 - PHO access to phone advice from secondary services
 - Provision of face to face Consult Liaison Services by secondary services
 - Shared Care arrangements
- ✓ DHB secondary services should be solely responsible for:
 - Managing compulsory treatment
 - 24 hour mobile crisis response
- ✓ Other services required by this group but NOT the role of the DHB secondary services include:
 - Meeting physical health needs (may have some role in identification)
 - Provision of short term practical supports
 - Provision of additional supports to preserve safety
 - Professional Advocacy

For those people with severe mental illness who have ongoing support (rehabilitation) needs even when relatively well.

- ✓ There is a need for greater alignment and partnership between DHB secondary services and NGO mental health services. In particular the working group recommended that there should be a single plan for meeting the needs of each service user. This plan should be jointly developed between the service user, DHB and NGO services and should clearly define the roles and responsibilities.
- ✓ The DHB core role and function should be focused on:
 - Assessment of illness
 - Development and implementation of a plan to treat illness
 - Identification that the person has ongoing support needs (initial support needs assessment)
 - Managing compulsory treatment
 - 24 hour mobile crisis response
- ✓ The NGO core role and function should be focused on:
 - Ongoing assessment of support needs
 - Development and implementation of a plan to meet support needs
 - Coordination of support services
 - Provision of short term practical supports when necessary
- ✓ In the short to medium term the PHO role should be focused on meeting physical health needs of this group of service users. There may be a need for future consideration of the PHO role in relation to the provision of mental health services for this group once the capacity of PHOs has developed further.

Project Management Group Decisions

The project management group accepted and endorsed the recommendations of the working group in respect to the core role and function of the CMHCs.