MHDA Service Transformation Project

Underlying Principles from Mental Health Review and Key Policy Directions

- Contemporary model of care
  - Better align services with demography and need
  - Ensure an equitable spread of services
  - Least restrictive care / closest to home / recovery focus
  - Increasing community services & residential care, with a focus on multidisciplinary input, peer support and integrated models
  - Decreasing inpatient care
- Better address needs of Aboriginal people & people in rural and remote areas
- Ensure a cohesive and integrated system of care
- Use funding to the best effect for the health of the population

Elements of the future MHDA service model

Contemporary model of care - least restrictive, closest to home and recovery focused

1) Build effective community services
   a. Multidisciplinary Mental Health Drug and Alcohol Teams
   b. Peer support
   c. Comorbidity Focus
   d. Integration and partnership models

2) Equitable spread of services
   a. Hub, Node and Spoke model
   b. Realign services based on demography and need
   c. Rural and Remote Support Strategy
   d. MHEC - enhance centralised acute function

3) Invest in community services and then adjust inpatient services
   a. Transition of long stay consumers to more appropriate facilities
   b. Assertive Community Treatment Function in Hubs
   c. Continuing care and extended hours acute care function in hubs
   d. Step up step down model
   e. Adjust inpatient services to reflect need
Description of Key elements of the service model

1. The hub, node and spoke model
   - Hubs: Orange, Bathurst and Dubbo
   - Strengthen Bathurst as a hub for Mudgee and Cowra and
   - Focus Dubbo as a major outreach hub to the North West communities.

2. Multidisciplinary Community Mental Health Drug and Alcohol Team (CMHDA Team)

   Multi-disciplinary community mental health and drug and alcohol teams will be created through designated positions, generic positions, and at times a mixture of both. The provision of core mental health clinical interventions will be provided by: Nurses, Psychiatrists, Psychologists / Clinical Psychologists, Social Workers, Occupational Therapists, Aboriginal Mental Health (and Drug and Alcohol) Clinicians and Trainees. The CMHDA Teams will also include Drug and Alcohol Counsellors and Peer Workers. The teams will work closely with other services and agencies to ensure a cohesive and integrated system of care.

   The volume, mix and spread of staffing is based on planning data and projected need. This will be achieved through new service models, re-allocating existing positions as well as some new positions staged over time.

   In the 3 Hubs the Multidisciplinary Community Mental Health Team has the following functions:
   - Acute Care Treatment and Continuing Care

3. Continuing Care and Extended Hours Acute Care Treatment (Bathurst, Dubbo, Orange)

   Continuing care refers to the ongoing clinical case management role of supporting people experiencing mental illness. It involves assessment, treatment / therapeutic interventions, care planning and care coordination. As well as a continuing care function, the community mental health team in each hub will have an acute care treatment function. The primary aim of the acute care treatment function is to assess and support clients at the point of presentation, whether this is, for example, their home, police cells, or the ED. This enables the support of a person as close as possible to their home, reducing the need for transport to ED and hospitalisations that could be avoided. The Acute Care Treatment role is to provide community treatment during the acute phase of a client’s presentation. It will cover the life-span and involve anything from a once only contact to two or three times a day and cover a 7 day a week roster, 0830-2300. The District wide MHEC-RAP service will provide the acute care function for the smaller centres via video after 5.00pm and for the Hubs after 11.00pm.
4. **Assertive Community Treatment Function in the Hubs (ACT)**

ACT is multidisciplinary and provides ongoing recovery oriented assessment and assertive treatment and care. It is aimed at improving the quality of life of people with complex mental health needs, requiring intensive intervention in a community or residential setting. These clinicians work intensively with people and their families experiencing severe mental illness with the aim of increasing hope and assisting people to live a meaningful life in the community, reducing the need for hospitalisation.

5. **Centralised acute care function (e.g. MHEC-RAP)**

The Mental Health Emergency Care - Rural Access Program (MHEC-RAP) is a critical element of the mental health service model. It was established as an emergency service with a 24 hour, 7 days week information and support line. It provides clinical assessment throughout the district avoiding a great deal of unnecessary transportations and admissions to inpatient facilities. It fills the gaps and provides support to Community Mental Health teams when they need it. There is an opportunity to extend this support through the use of technology while recognising the importance of providing services locally. Further workshopping is required to determine how changes would occur. Options to be discussed and explored further with the relevant teams include:

- Specialist clinics delivered through video link e.g. Early Psychosis; Infant Perinatal; Personality Disorder
- Extend capacity to undertake discharge planning when appropriate without referring to local Community Mental Health Teams.
- Updating the name to reflect extended acute care function and district wide community support service as well as emergency service function
- Potential to co-locate / Integrate Mental Health Emergency Care - Rural Access Program (MHEC-RAP) and Drug and Alcohol Helpline (DAH). Work to support the implementation of the MHDA Comorbidity Framework.


The Rural and Remote Support Strategy aims to ensure better access to care for people residing in smaller rural and remote communities with no local community MHDA team, through the introduction of dedicated rural and remote clinical support positions. These positions will be based in community teams across the LHD and will engage with identified rural and remote communities to support, build and strengthen an integrated MHDA service response. The clinicians will provide this through the direct delivery of specialized therapies, and/or supporting other service providers to deliver targeted interventions. The team members will have the capacity to engage in areas of targeted need, for example closing the gap strategies, critical incidents and progressing integration initiatives. The clinicians will be virtually networked across the LHD and coordinated as a virtual team for the purpose of clinical support, coordination and planning, with the agility to respond to shifting needs throughout the district. In addition to these dedicated rural and remote clinical support positions, there will continue to be clinical positions in the Hubs and Nodes that have an outreach component to their role, as well as other positions with a capacity building focus eg prevention/early intervention, education, partnership, coordinators etc.
7. Step up Step down model
Step up/down services are community based services that can be located in the community or on hospital grounds. These services are designed for people who require higher level of treatment and care to reduce symptoms and/or distress that cannot be adequately provided in the person’s home but does not necessarily require an admission to an acute inpatient unit. The term step up refers to the increased level of care, i.e. from a community/residential setting. Step down refers to the decreasing level of care, for example a person being discharged from a psychiatric facility, needing additional support prior to returning home. Step up/down facilities are delivered by multidisciplinary teams operating as part of a local integrated mental health service system. Services can be delivered as collaborations between specialist clinical and community support sector services with staff available on site 24 hours per day.

8. Mental Health and Drug and Alcohol Comorbidity focus
Co-morbidity is common, affecting over 300,000 Australians. People with psychotic disorders are 5 times more likely to have a drug use disorder and 2 times more likely to have an alcohol use disorder and high levels of nicotine dependence. Co-morbid mental health and substance use problems occur in up to 71% of people in mental health services and 90% of people in substance use treatment centres. The MHDA Service will work to raise awareness of and implement the NSW Clinical Guidelines for the Care of Persons with Co-morbid Mental Illness and Substance Use Disorders in Acute Care Settings. This includes programs and education to improve the knowledge and understanding of co-morbidity in the drug and alcohol and mental health service as well as other services and agencies who play an important role in identifying and responding to people with comorbidity issues.

In order to support this cultural shift in the mental health and the drug and alcohol services, the Drug and Alcohol helpline will be co-located with MHEC-RAP mental health emergency access line. A senior Drug and Alcohol position will also be located with MHEC-RAP to work with the Mental Health CNC to support MHDA service integration and the implementation of the co-morbidity guidelines while maintaining specialities in both drug and alcohol and mental health.

In 2016 the Community Health Outpatient Care (CHOC) information and data system will be rolled out in Western NSW LHD. This will be of considerable significance in supporting shared information and integrated care.

9. Integration focus
In the future service model incorporating contemporary models of care, integration is a key focus. Integrated care involves the provision of seamless, effective and efficient care that responds to all of a person’s health needs, across physical and mental health, in partnership with the individual, their carers and family. In regards to the Western NSW Mental Health and Drug and Alcohol service, there is a focus on integration internally between mental health and drug and alcohol services and with the LHD’s other health services, with primary health, other government agencies and the community managed sector. Specific initiatives include:

- LHD Community Mental Health Drug and Alcohol Team
- Western NSW LHD Integrated Care Strategy Pilot Sites
• LIKE MIND – NGO Partnership, community based, integrated co-located community service providing care across mental health, primary health care, drug and alcohol treatment and vocational supports (to be piloted in Western NSW LHD)
• Reach out Pathways Project – Integrating online and offline support through a stepped-care approach
• Integrated GP Clinic – for people with complex mental illness in Baradine
• Ongoing development of integrated and co-location models
  • in nodes and spokes
  • Coonabarabran/Coonamble

10. My Choice, Pathways to Community Living
(Formally, Hospital to Community Initiative)

Western NSW LHD is the Pilot site for this NSW Hospital to Community Initiative. New community residential options will be designed for the 380 people currently receiving long-term (over 12 months) hospital care in non-acute and acute mental health inpatient units in NSW. Of these approximately 34 are currently long-stay patients in Western NSW LHD inpatient units. Currently each one of these long-stay patients is being clinically assessed and staff are working with each of them to create a plan based on their individual needs. Transition to community living will depend on each individual’s particular needs as well as on tailored housing, clinical care and available psychosocial support. To achieve this, transition will occur in stages over a number of years to ensure the variety of accommodation options is available to meet clinical needs. It is anticipated that the new Mission Australia aged care facility to be opened on the Bloomfield Campus in June 2016 will be a possible option for a number of long-stay patients in Bloomfield inpatient units. MHDA services are also working to develop Specialist Mental Health Services for Older People (SMHSOP) in-reach capacity and clinical function to support older people with high support needs re-locating to residential aged care facilities.

In addition to this state initiative the Service Transformation Project has a broader focus in ensuring that all current mental health clients are receiving contemporary models of care and that this care is provided by the most appropriate agency or in partnership.

The Mental Health Drug and Alcohol (MHDA) Service Transformation Project has now moved into the implementation phase. Over the next 2 years the MHDA service will be working in a planned and staged way to move to the future service model. It is based on a model of care that is the least restrictive, provided as close as possible to home and with a recovery focus. It will involve significant change over time to ensure a multidisciplinary approach, an equitable spread of services based on demography and need working to better address the needs of Aboriginal people & people in rural and remote areas

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