BEST PRACTICE MODELS

BEST PRACTICE MODELS for Continuing Care of Persons with Mental Disorders

[7] Engagement with ongoing care

a) Community Mental Health Services

b) Outreach services

[7 a] Community Mental Health Services

Under National Health Plans each State designates an appropriate number of Health Regions which each contain Level One (University-affiliated) public teaching hospitals, a cluster of Level Two public and private community hospitals, and a widely dispersed network of local Community Health Centres. This paper contends that all Level One Hospitals should have Tier Three mental health centres and that all Community Health Centres should have Tier Two mental health programs supported by the Tier Three specialists on an outreach basis. This is to ensure a system that provides:

- prompt intake assessment and short-term treatment, regardless of the level of severity,
- triage to appropriate facilities for specialist management when indicated, without additional intake barriers,
- ongoing long-term management when indicated,
- consultative services on an outreach basis when needed.

Tier Three specialist mental health services should provide:

- In-patient and Day-patient programs for severe mental disorders,
- Specialist assessment and management of programs in age-specific strata
    - Geriatric
    - General adult
    - Adolescent
    - Children and families
- Outreach programs (see also Project Evidence paper PE 7b) which provide:
    - Community Assessment & Treatment (CATT) Teams
    - Intake/Brief intervention at Community Health Centres & Public Hospital Emergency Depts.
    - Consultancy services to relevant Tier Two and Tier One agencies

Tier Two Community Health services should provide:

- Face-to-face intake and brief intervention programs
- Family therapy programs
- Case management support and treatment monitoring
- Group therapeutic programs
- Specific purpose programs for substance abuse, domestic violence, parenting & child behaviour management.

Case assessment is described in paper PE4 and the approach to short-term assessment and treatment is described in PE5b. The case management (continuing care) program is described in PE7a. This is a comprehensive plan of care for an individual client that describes:

- The client's problems, needs, and desires, as determined from the findings of the client's assessment.
- The strategies, such as treatments and interventions, to be instituted to address the client's problems and needs.

- The measurable goals – including specific outcomes – to be achieved to demonstrate resolution of the client's problems and needs, the time frame(s) for achieving them, the resources available and to be used to realize the outcomes, and the desires/motivation of the client that may have an impact on the plan

Case Management Plans cover not only the individual but also the family and social circumstances including health, welfare, housing, employment and wellbeing needs. This often necessitates collaboration between the therapist and other statutory and non-Government agencies. This is particularly so for clients with special needs, such as physical and intellectual disability or acquired brain damage involving Disability Support or NDIS involvement.

This pattern of service delivery requires adequate numbers of trained staff at all facilities, sessional deployment of staff across programs, and funding and management models that ensure collaborative service delivery for optimal client outcomes.

Adequate numbers of trained staff can be achieved by planned sponsorship of trainees through the specialist mental health training program. The employment numbers need to be sufficient for the population demographics of the area.

Staff in Tier Three programs are, by definition, trained mental health specialists, but only the best qualified and experienced ones should be utilised for the outreach programs. Consultancy, intake and brief intervention programs require the highest skill levels.

To counteract the natural tendency of managers to cater to their own preferences rather than the network's, the following constraints are recommended:

- One half of Tier Three staff hours should be on outreach programs, and one half of that deployment should be at Community Health Centres and consultancy in a manner mutually agreed by a committee of the donor and recipient agencies.
- The Key Performance Indicators for the service providers should include satisfaction of the service recipients.

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