PROJECT EVIDENCE

PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[5] Early Treatment

a) Universal Health, Welfare and Educational agencies in the community [Tier 1]
b) Private practitioners and Community Mental Health services [Tier 2]
c) Specialist Mental Health services [Tier 3]

Mental health disorders occur throughout the community at various levels of severity. At present, diverse private and public sector agencies respond to aspects of mental health need in an un-coordinated manner. MHYFVic proposes a coordinating framework to ensure that appropriate care is delivered. This is described in Project Evidence PE 5 a.

[5 c] Specialist Mental Health Services

Public sector specialist mental health services have a mandate to respond to the needs of the whole community, but with finite resources must prioritise urgent cases that are not able to be treated elsewhere. In particular, they must give priority to inpatient management of seriously mentally-ill patients in designated mental health facilities. The next priority is management of those cases outside the hospital setting. Only then can some resources be allocated to less serious degrees of mental disorder.

It is appropriate to triage the referrals and have significant barriers to intake of new cases into the hospital system so as to preserve its limited capacity from being inundated with cases that could be treated in community settings. The inherent fault has been that cases refused admission were not then adequately treated. The MHYFVic proposal is for all intake triage to be undertaken at Tier Two Community Mental Health Services. There should be no direct referral to Tier Three units. All referrals for specialist mental health services should come through the intake service at Community Health Centres (Tier Two), staffed by Outreach Workers from the Tier Three services. In this way the specialist services can maintain control of their admissions whilst simultaneously ensuring that cases not admitted to the specialist units are provided with supported programs within the Community Health Centres.

The same Tier Three services outreach staff acting as intake workers at Community Health Centres would also provide the same service at Emergency Departments at General Hospitals and by outreach Community Assessment and Treatment Teams responding to emergency calls in the community (such as Involuntary Admission recommendations from GPs).

This proposal requires a considerable sharing of staff between the Tier Three and Tier Two services. Whilst Tier Two staff would do the bulk of case management work, the Tier Three staff would contribute the specialist intake/assessment and short-term therapy expertise, plus ongoing supervision of long-term care. Although such job-sharing poses management difficulties, it also provides considerable professional benefits. Staff would experience a wide range of mental health problems at varying levels of severity, and see a number successfully resolved, rather than being constrained to one aspect of the range. This is likely to enhance job satisfaction, work flexibility and staff retention.

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 clinicians at Community Health Centres and Public Hospital EDs.
    - Consultancy services to relevant Tier Two and Tier One agencies

As this project is focused on child, adolescent and family clientele, it will omit discussion of geriatric and general adult mental health services.

CHILD & ADOLESCENT MENTAL HEALTH SEVICES

Traditionally, child and adolescent mental health services have been stand-alone facilities, almost unrelated to other components of the health care system. They provided both highly specialised neuropsychiatric programs as well as generic child and family therapeutic programs of a Tier Two type. As such, they experienced chronic under-resourcing for the known community caseload, but also the obstacles to utilisation caused by stigma and lack of knowledge about their roles.

Given that most adult mental health disorders begin in childhood and adolescence, and that early intervention is more effective than treating established disorders, it is cost-effective resource allocation for improved CAMHS. However, as many cases can be treated at Tier Two level, the proposed MHYFVic model of Intake/Assessment and Short-term treatment at Tier Two level is equally applicable to CAMHS as to adult services. The specialist multidisciplinary programs (such as autism spectrum assessments, early psychosis assessments and infant assessments), could remain at the Tier Three level whilst many generic therapeutic interventions would benefit by decentralisation to local Community Health Centres.

YOUTH MENTAL HEALTH SERVICES

In earlier decades the child and adolescent mental health services catered for the 0-18 year age range and adult services catered for the 19 year upwards age range. Younger adolescents were therefore managed within a CAMHS family-centred psychosocial context whilst the older adolescents were managed within the adult individually-centred service model. In recent decades a youth mental health stratum has developed to cater for a 16-25 year age range during which there is a transition towards self-reliance and independence depending upon the circumstances of the person, rather than an abrupt shift that often did not match the needs of the person.

The proposed MHYFVic model of Intake/Assessment and Short-term treatment at Tier Two level is equally applicable to Youth Mental Health Services as to CAMHS and adult services. The specialist multidisciplinary programs (such as substance abuse assessments, early psychosis assessments and juvenile justice assessments), could remain at the Tier Three level whilst many generic therapeutic interventions would be better undertaken at a Tier Two community level, including at age-appropriate agencies such as Headspace.

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