

The management of change in a Community Mental Health Team

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Abstract

Assertive Community Treatment (ACT) is the most widely studied and well supported evidence based community management model for persons with severe mental illness (SMI) in the mental health literature. This report details the replacement of an unevaluated generic model of case management with ACT in a metropolitan inner city area. This is work in progress and detailed patient outcomes are not yet available. The steps taken and the problems encountered in changing clinical practice are important over and above the intervention itself and are discussed.

The main difficulty that we encountered was moving staff from focusing on and becoming demoralised by potential problems and obstacles to problem solving and implementation of the best available solution. Staff were consulted at all stages of the project. The use of an 'action research' strategy maximised their sense of ownership and ultimately enabled the project to be implemented although in a revised format to that originally envisaged. Flexibility in this regard was crucial since the budget granted was only 40% of that requested.

The original aim of having all 3 sector teams of the Inner City Mental Health Service (ICMHS) involved did not eventuate due to internal organisational issues and only one team undertook to implement the ACT approach.

Community care

This project concerned change management and addressing service delivery systems and quality within the ICMHS at Royal Perth Hospital serving an inner city population of approximately 45,000 people. It involved the community unit that consisted of three teams (East, West and Central). The teams were multidisciplinary: each contained psychiatrists, registrars, psychologists, social workers and case managers. The teams were part of an integrated generic service having access to their own inpatient facilities and specialised day programmes for cognitive therapy, living skills and personality problems.

There are many different models of community care with some claiming greater efficacy for more intensive forms. However this has been disputed and in a meta-analysis Marshall et al (1999) concluded that generic case management (which incorporated all forms of case management other than assertive community treatment) increased patient hospitalisation rates with no evidence of improvement in mental state, social functioning or quality of life.

Assertive Community Treatment (ACT) is a community-based alternative to hospital care, delivering the equivalent comprehensive services directly to SMI patients in the community in an integrated manner. The main benefit of integrated service delivery is that it affords continuity of care and therefore an opportunity to develop a therapeutic alliance (Krupnick et al 1995). Persons with a severe mental illness and often co-occurring substance abuse problems who receive integrated services in the community for at least a year function better (Jerrold et al 2000). The goals of ACT are to ensure that the patient is able to remain in the community with the highest possible quality of life.

In the original study (Stein & Test 1980), 130 patients were randomly allocated at the point of admission to hospital to an intensive community based service, or to hospitalisation followed by traditional outpatient care. At the end of 12 months, subjects in the experimental service had spent significantly less time in hospital and had superior clinical and social outcomes. Similar results have been reported from other countries including Australia (Hoult 1983).

ACT is, in the short term, more costly to deliver than generic case management. However, it yields far greater cost savings in the long term because its aim is to rehabilitate rather than manage symptoms, and thus reduce the long term burden on a health system. The low functioning patients who are the focus of ACT do not respond to the fragmented and sometimes contradictory sequential or parallel models of care (Ries 1993; Poland 1998), in which they invariably utilise high levels of costly inpatient care (Drake et al 1998).

Table 1 shows a comparison of the key attributes of this approach with the situation in ICMHS prior to commencement of the project. The table reveals that the ICMHS approach prior to the project incorporates some of the elements of ACT, but the caseload is much higher, the treatment package is not specialised and there is no culture of evaluation.

Table 1: comparison of ACT and the approach in use by ICMHS

Characteristics	ACT	ICMHS
Client Mix	SMI	SMI
Staff/Client Ratio	1:10-1:15	1:30
Frequency of Contact	Daily	Weekly - Monthly
Team Structure	Staff provide most of care	Staff provide most of care
Emergency	By team	By team
Out of Hours	By team	Hospital/Psychiatric Emergency Team
Treatment Base	Community	Community
Hospital Admission	Controlled by team	No direct control
Treatment Orientation	Practical plus specialised (eg, family therapy/CBT provided by team)	Care often provided by other agencies
Outcome evaluation	Explicit with goals negotiated with patient	Limited evaluation
Social Care	By team, as important as medical treatment	Depends on profession of case manager

Project vision

The project was funded under the quality improvement programme of the Department of Health (Mental Health Division). The programme is concerned with 'improving the effectiveness of mental health service delivery by using current research-based evidence'. The definition of quality from a consumer perspective is fraught with difficulty in some areas of mental health where patients seek to avoid contact with services altogether. Hence the approach used should be seen in Garvin's (1984) terms as product-based, since patients' views were not ascertained, although we were in possession of feedback from secondary consumers including hostel managers, GPs and carers.

The concept of a quality chain is particularly useful, given that a patient's care at times of crisis is often spread from the principal responsible team through to emergency services and other hospitals. This pointed the way to the critically important task of briefing them about the project and using their feedback in its design. Despite our not formally involving patients in the design phase, the project could be expected to improve many of the service quality factors described by Berry et al (1985) such as reliability, responsiveness, competence, access and understanding.

The factors driving change included the following.

- A. Overworked case managers (self-reported)
- B. Reactive and outdated patient management processes with little if any proactive attempts at genuine rehabilitation (comments of former staff member at exit interview which were supported by one of the team consultants and the senior nurse manager)
- C. Low morale evidenced by self-report and high staff turnover
- D. A lack of processes and protocols to guide patient management
- E. Failure to meet Department of Health guidelines such as the review of patients within 5 days of discharge from hospital
- F. A clear willingness to address problems within two of the three sector teams
- G. A commitment to the consultant's view in East Team that a change of work practice with a reengineering of service delivery was possible
- H. Clinically competent and committed case management staff (ie, problems were the result of the service structure and its operation).

The main route to improving quality was the reengineering of the service delivery system in conjunction with setting service standards for the performance and content of the newly designed service. Frequent discussions with the involved team members ensured that the project was measurable, realistic, consistent with service aims and values, expressed clearly and would deliver real quality improvements as required by the National Standards for Mental Health Services (AHMAC Working Group 1996). We wanted this new model to become part of the service fabric so that it continued after the seed funding had expired. Further desired outcomes were as follows.

- A. Focused on the SMI patients who are high users of inpatient services and have multiple needs. They are often those who resist or avoid involvement with mental health services.
- B. Engender a culture within staff of objective evaluation of patient outcomes.
- C. Enhance the expertise of community staff through training, and using these additional skills in the management of patients.
- D. Assume responsibility for directly providing needed treatment, rehabilitation and support services, including substance abuse, employment and rehabilitation services.
- E. Minimally refer clients to outside service providers.
- F. Provide services on a long-term basis with continuity of caregivers over time.
- G. Deliver at least 75% of services in the community.
- H. Emphasise outreach, relationship building and individualisation of services.
- I. Intensity of service provision to be dependent on patient need but to average 2 hours per week (ie, 2-3 visits).

Implementation

Change processes that fundamentally affect the work patterns of clinical staff are more likely to be successful if those staff are closely involved in the project and supportive of its aims. The strategy used was one of action research (Tobin et al 1997). This approach reduced staff resistance although meant that the final structure was somewhat different from the original idea. Planning began in 1998 and involved the following.

- Weekly meetings of the staff of the identified team with a review of the literature and consideration of the advantages and disadvantages of changing work patterns.
- Following acceptance of the need to change and of ACT as the preferred method of service delivery, the formation of a project control group from the broader service.
- Investigations by the control group revealed a similar local programme in Fremantle. Following an invited presentation from their staff and stated interest from the Centre for Mental Health Services Research a combined project was agreed.

An implementation plan was developed by the clinicians under the guidance of the project manager. Staff were trained in the objective assessment of patients using the Life Skills Profile (Rosen et al 1989), Brief Psychiatric Rating Scale (Rhoades & Overall 1988), Health of the Nation Outcome Scale (Wing et al 1996), Montgomery Asberg Depression Rating Scale (Montgomery & Asberg 1979) and the Mania Rating Scale (Bech et al 1978).

Three days of training were provided by Next Step, the State provider of services to those individuals with substance abuse problems, to assist in the management of patients with comorbid drug and alcohol issues. A detailed service specification was drawn up including intake, discharge and review procedures.

The redesign required case managers to reduce their caseloads from approximately 30 to 15. Alternative management strategies were constructed for the patients no longer receiving case management services and their continued progress was monitored. Negotiations were undertaken with principal stakeholders such as Graylands Hospital (the State's only remaining psychiatric institution), and major non-government organisations (NGOs) such as Daughters of Charity. The project manager also undertook a confidential review of staff views.

The new system commenced in December 2000 with the project manager identifying and assessing a control group of 50 patients to act as a comparator. Arrangements were made to undertake a benchmarking exercise with Royal North Shore Hospital, widely seen as the premier Australian model.

Planning model

The planning process can be broken down into separate steps. It was necessary to start with a clear idea about what we were attempting to do. In this instance the broad mission was to improve the care of patients living in the community with SMI. The aim was to deliver treatment to patients in the community as effectively as possible and to change the culture of staff delivering that treatment such that objective assessment became part of routine practice. The specific objectives were to reduce hospitalisation (by approximately one-third consistent with the international literature) and improve mental state and psychosocial adjustment by clinically significant levels.

We might have tried to assess the outcome for patients under our old system before contemplating the larger change management project. However, we would have had the problem of trying to find the time and training for our case managers along with the necessary change of culture even to achieve this. It was easier, therefore, to undertake the project with the built-in change components from the start.

An extensive literature review was conducted, using sources that conform to the standards of evidence-based practice. This led to a formal comparison of how the current service compared to that of ACT and an assessment of what realistic changes could be made within the environment in which we operated. One of the driving forces behind the project was to reengineer the team such that a better outcome could be achieved within the same resource framework. However, there was the need to input resources to maintain at various times the old system, the transition phase and the future phase as it was implemented. Hence funding was sought for a project manager and some incentives for staff.

We had some problems with the planning process with staff misunderstandings. The repeat of some of the groundwork by the project manager, and the long lead-in time with staff changes, resulted in some being unaware or misinformed about the project. Dealing with these issues meant that in reality there was an iterative rather than linear approach during planning.

Outcomes

Some of the changes that have occurred have been very general and are not necessarily related to ACT. For example, all patients now get a medical diagnostic review and formal three- or six-monthly medical review. The team meets daily, and there is a streamlined allocation process for new patients. However, it was much easier to introduce these changes in an environment where members of the team actively questioned how and why things were done and felt empowered to change them. Case managers have undertaken training in the management of alcohol and drug problems and this has led to the opportunity for networking with staff from Next Step.

Most importantly, objective criteria are now used for the allocation of patients to ACT and there is a specific minimal treatment package for each patient. We have noted an improved interface with NGOs leading to a memorandum of understanding with one of the major ones. Weekly team education meetings with appropriate review of the literature allow us to reinforce concepts such as evidence-based treatment. Future expected outputs include ongoing formal patient outcome assessments, measurement of treatment fidelity, and ultimately improved patient health.

Discussion

The ingredients for change and 'unfreezing' (Lewin 1947) were present given the dissatisfaction felt by team members and the willingness of many of them to contemplate change. In implementing changes, the psychological progression as described by Handy (1993) was evident. There was an awareness of the need for change, willingness to follow the consultant's lead (ie, an initiating person), adaptation of the strategy by team members and, possibly as a result, a less than optimum final model.

However, keeping resistance to a minimum was crucial and the action research strategy allowed the team to follow the advice of Kotter and Schlesinger (1979) and use strategies such as education and communication, participation and involvement, facilitation and support, and negotiation and agreement. These are amongst the more time-consuming approaches and explain why an idea first put forward in 1998 did not get underway until late 2000.

The original aim was to involve all three of the inner city teams. This was reduced later to two due to resistance within one of the teams. In the event, only the East team has so far successfully implemented the approach. Some East team staff complained of 'losing momentum' so it may have been possible to have completed some tasks more quickly if only this team had been involved initially.

The problems in the other two teams were different. Despite the education and participative approach, the staff of Central team could not be convinced to take part. Their consultant in particular remained unconvinced of any real benefits. The West team agreed, but the lack of a central figure taking control of the process within that area effectively meant that successful implementation did not occur.

Communication is vital and all standard methods were used. Whilst written memos, telephone conversations and meetings were all important, the most critical aspects were the interpersonal communications between various team members. One problem that was encountered was that the lead project investigator was also a team consultant and department head. This had advantages in getting things done but also potentially led to boundary difficulties within the various roles. It was important therefore to allow staff to provide feedback anonymously to the project manager.

Frequent written feedback following meetings and a guidance document allowed staff to refresh their memories on what stage the project was at and what had been agreed. Regular weekly meetings assisted this process.

Action research is one way of combating the false assumptions that are often made when trying to account for the behaviour of others, such as 'the real world is all that counts, everyone works for the same goals, and the facts speak for themselves'. Indeed, the feedback to the project manager revealed some of the concerns and 'worlds' within which other staff operated. The motivation of the East team to change things was high, due to articulated difficulties.

It may also be the case that inherent factors within the team members as described by Maslow (1970), such as self-actualisation, also played a role, although these were not formally examined. Therefore a key goal was to minimise the misperceptions and misunderstandings of team members in order to capitalise on these motivators and so lead the team towards identifying and achieving a new set of goals.

One way of considering this area is through the link between effort and performance. This means recognising the need for clarity of objectives, ability and skill, and level of resourcing. Given that the project directly approached the first two issues, it was both implicit and made explicit within team briefings that the project could lead to permanent extra resourcing.

Performance is also linked to job satisfaction through outcome, in this case at least partly determined by the outcome of patients. The project, for the first time, would give case managers more objective outcome data on

some of their most difficult patients. It also followed the principles of job enrichment (Herzberg 1968) with the case manager having a more complete natural unit of work (ie, less contracting out to others to achieve aims), the introduction of new and more specialised tasks, and the training to go with this.

The strengths of this project included its collaborative, action research approach. Agreements with other service providers led to best use of resources. It was constrained by staff resistance to change, and budget difficulties although this led to some innovative ways of saving money, such as joint training arrangements with Next Step. We await the demonstration of improved outcome for patients, and we need to continue to monitor the effect on staff. For instance, will they suffer burnout, and can they adhere to ACT without other demands taking over? The confidential review of staff will be repeated and we hope there will be future expansion to other teams and services.

It would be gratifying to be able to report that the project has been totally successful, but real change in a front line mental health service with little in the way of funding to accomplish this is not easy. The main problem is staffing changes, not only within the team but also at the senior levels of ICMHS. This brings in individuals with different ideas and priorities and the promotion of one of the key individuals driving the project to other tasks within the broader hospital makes it difficult to sustain the change process and leads to the ongoing need to redefine the aims.

It is encouraging that, at a recent medical advisory committee, there was a unanimous commitment for different patient subgroups to be treated according to specifically developed evidence-based protocols and for the service to ensure that staff have the necessary training to carry these out. In essence this will keep alive the cultural changes that the ACT project has achieved.

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