The beginning of a structural reform: Reorganising the front line of a mental health service

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Abstract

National and State priorities for mental health services have directed emphasis towards early intervention and prevention. One of the key priorities is to ensure that entry to mental health services is efficient, effective and accountable. This study describes the process of restructuring the front line of a large and complex mental health service. Adopting the total quality management approach, all stakeholders in the service collaboratively developed a single set of protocols and guidelines to achieve standardisation of documentation, assessment of risks and urgency, and to improve the overall quality of the service.

Introduction

A major challenge to public sector mental health services of the Second National Mental Health Plan (Australian Health Ministers 1998) lies in the requirement to move towards a greater emphasis on promotion, prevention and early intervention. One of the key features of such a direction is ensuring detection of mental health issues at the earliest possible opportunity and minimising the risk of people being 'turned away' inappropriately because their symptoms are not sufficiently severe and well developed. After a decade of prioritising chronic mental illnesses, there is a great deal of work to be done to adapt to this new direction while at the same time maintaining quality and effectiveness in long-term mental health services. This adaptation requires a systematic approach to service organisational change.

Smith (1998) identified two types of culture that may impact on change processes. These are corporate culture and national culture. The former refers to the visible and covert practices of the organisation and are amenable to an assertive and well lead change management process. National culture, on the other hand, refers to the attitudes/behaviours and expectations of the people of the country as a whole and is susceptible to only slight change over longer periods of time. The interaction between these two cultures will impact on the eventual outcomes of the change process. This is an important issue for the current impetus to change which is reflected within the first and second National Mental Health plans (Australian Health Ministers 1992, 1998).

The drive of the first plan was to de-institutionalise and mainstream mental health, and provide appropriate community-based services. One of the key directions of the second National Mental Health plan is to increase emphasis on prevention and earlier intervention. Unfortunately, it is recognised that in many mental health services the implementation of the first National Mental Health plan is incomplete, and many people with chronic mental illness are still receiving less than optimal care in community-based services (New South Wales Acute Care Working Party 1997). At the same time, community expectations are increasing. One of these is that mental health services will have a major role in the control of many behavioural problems. Thus, staff of community mental health services are under pressure to do three distinct tasks. These are:

- to provide improved effectiveness of care for people with chronic mental illness in the community
- to play a role in assessment and symptom monitoring of people with behavioural problems, and finally
- to facilitate early access to treatment so that opportunities for prevention and early intervention are not lost.

These broad-based community expectations, which may draw health systems in opposing directions, are the context in which local organisational system change must occur.

Mental health services reform

One of the key issues is ensuring that the front line of mental health services (access and intake systems) is efficient, effective and accountable. This article discusses efforts of a public sector mental health service to reorganise the front line of its service, so as to achieve these goals. Improving access is a key goal aimed at improving the quality of the mental health services and enabling them to become more customer-focused.

There are two important aspects to the improvement of access: triage and comprehensive assessment. Triage is the decision involving the initial screening of all incoming referrals, undertaken by a health professional. The aim of triage is to facilitate a timely and appropriate response to client presentation and to make a decision about the most

appropriate service (internal or external) to which the client should be referred. This is based upon the assessed need of the individual and a sound knowledge of all available health services. Triage categories have been used widely in emergency departments in general hospitals for decades as a means of prioritising people who present there but little specific attention has been paid to mental health issues in this context (Smart, Pollard & Walpole 1999). Similarly, a systematic triage process in community mental health services has not been provided.

Improving access requires reform of the entry process to mental health services. The National Standards for Mental Health (1996) state that mental health services should be available 24 hours a day, seven days a week (Std 11.1.4) and be coordinated through a single entry process (Std 11.2.3) (Australian Health Ministers' Advisory Council 1996). This is affirmed by New South Wales' mental health policy. In *Caring for Mental Health: A Framework For Mental Health Care in New South Wales*, a stated requirement is for a single entry point system to be in place by 2000 (New South Wales Health 1998). Services will be required to demonstrate that systematic assessment documentation is available within 48 hours of entry. Such systematic assessment is pivotal when a client initially contacts the mental health service in order to prioritise urgency of need.

For many patients this should be followed by comprehensive biopsychosocial and cultural assessment at the earliest stage of illness, in order to provide the best basis for making decisions about treatment, monitoring progress and developing a management plan (New South Wales Health 1998). Part of an effective comprehensive assessment system will be ensuring that specialist public sector mental health services target the clients for whom public sector interventions are most appropriate, and make effective appropriate referrals to alternative providers where possible.

Benefits of improved entry system

Improved access to mental health services is said to reduce unnecessary hospitalisation, improve outcomes, reduce financial costs for health providers and encourage early recognition of symptoms (Forrest & Starfield 1998). It is the function of a well organised mental health intake and triage system to:

- prioritise referrals based on the level of urgency
- direct resources to manage emergency referrals quickly, and
- reduce unnecessary use of resources by limiting inappropriate utilisation of services when alternatives are available.

Inadequate recognition and treatment of symptoms may increase numbers of acute episodes, as well as chronicity and recurrence (Bindman et al. 1995). The potential benefits of early identification of risks and intervention have been delineated (McGlashan 1996).

In response to these challenges, one public sector mental health service embarked on a process to develop a systematic intake and triage process at entry point, and to provide standardised tools for a comprehensive assessment service when this was judged to be the most appropriate service response for the patient. This required the development of an agreed format for standardised assessments of risk and urgency, and the introduction of organisational change to make use of the new tools sustainable in routine clinical practice. This change was brought about using total quality management as the change paradigm.

Total quality management

In recent years, the total quality management approach to organisational change has been popular in the health care industry. Traditional organisational change theory describes changes from the 'top-down' approach where the leaders in the organisation make the decisions about the changes (Lord et al. 1998). However leadership, long-term commitment to change and engagement of staff in the process are all essential components of total quality management (Joss & Kogan 1995). Studies focusing on change management have reported that involvement of staff throughout the process of change can reduce potential resistance to change from staff (Tobin, Dakos & Urbanc 1997; Bullock 1983).

Coping with resistance to change

During change management initiatives, it is expected that there will be a high level of resistance from staff as people are asked to re-examine and modify their behaviour. Resistance is increased when the purpose of change is not clear, when people affected by change do not see the need for change to occur, and when they are not involved in the planning. This is exacerbated if there is poor communication and reward and incentives are inadequate (Henry 1997).

Organisational context

The South Eastern Sydney Area Health Service is a large metropolitan health service in Sydney, servicing a population of 740 000 (Australian Bureau of Statistics 1996). Within the service the mental health program is divided into four sectors, namely St Vincent's (inner city), Prince of Wales (eastern suburbs), St George, and Sutherland.

Each sector has an acute psychiatry inpatient unit and a community mental health team providing 24-hour care. Historically the four sectors operated fairly autonomously with local policies governing access and intake. Overarching responsibilities for pulling these four sectors together in a strategic direction lies with the Area Mental Health Strategic Planning and Service Evaluation Unit.

The mental health intake service is the frontline of each sector and is located at the relevant community mental health centre. The majority of new clients and those who are re-presenting contact the mental health service via the intake system with a minority coming via hospital emergency departments. Traditionally in South Eastern Sydney Area Health Service, decision-making in mental health intake systems has been based on individual clinical experience, intuition, and serial and repetitive assessments, as clients move from intake workers to clinical case managers to psychiatric registrars, each performing a separate, albeit related, assessment of need. From this perspective, it was clear that any restructuring of mental health services to better meet new national and State priorities had to begin at this entry point.

Baseline intake process

During business hours each of the four intake services is coordinated by a mental health professional called the Intake Worker. After hours, the responsibility for managing mental health intake presentations rests with a mental health crisis team, an on-call mental health professional, or staff of the inpatient unit. At the time of the intake presentation, details are gathered about the presenting problem and a decision is made about the level of urgency. From this an interim management plan is initiated. All such decisions are made based on the professional judgement of the person at the intake point. There were no systematically applied protocols or standardised tools to assist staff with the triage or prioritising decision in any of the sector services.

A decision was made to review this intake process in all sectors with a view to improving consistency and quality. Exactly how far towards achieving national and State priorities the process could be driven was not clear at the start.

Methodology of the change process

A steering committee was formed comprising all major stakeholders in the service. These comprised representatives of sector management and intake staff in all four sectors plus a nominee of the four local Divisions of General Practice and consumers nominated by the Consumer Consultative Committee. The steering committee was supported by the Area Mental Health Service Evaluation Unit and was chaired by the Area Director of Mental Health. This stakeholder approach to service review was used to encourage maximum participation in any subsequent change process.

The steering committee met monthly and discussed sector intake procedures. Agreement was reached that there were some inherent problems with each of the current systems and that there was a need to improve standardisation of intake decision-making. It was decided that greater consistency of access across the four sectors was also a worthwhile goal.

Each sector's intake system was reviewed by examination of the current forms, pathways to care and problems from the perspectives of general practitioners and consumers. The meetings provided a forum for discussion of these problems. Members of the committee participated in discussions about ways to improve the system. They provided input from their local perspective and gave feedback to their local sector as proposed new directions unfolded.

Through the discussion process the steering committee identified seven aspects of the intake system which required attention. They were:

- the lack of a systematic approach to triage and prioritising access
- the lack of benchmarks for timeliness of response
- repetitive assessments by different staff members
- the lack of any systematic risk assessment
- a multiplicity of paperwork and forms across different stages of the process
- inadequate feedback to referrers, and
- inadequate engagement of other providers, such as general practitioners.

In an attempt to develop solutions to each of these problems, small subgroups of the steering committee were formed to brainstorm the issue and recommend changes. As a result, suggestions were introduced to the committee which included developing a common, Area-wide intake and triage system. Benchmarks were proposed and agreement was reached on the necessity of developing a standard risk-assessment tool.

Outcomes of the process

There were six main outcomes of this process which are summarised below.

Unified Area-wide approach

Initially the steering committee had been of the view that the differences in socio-demographic contexts between the sectors were too great to allow standardisation of a common intake across the Area. The initial goal was therefore the development of broad practice guidelines which would set the conceptual framework in which all four intake systems would operate. However as the project progressed there was a shift in understanding. A new target was agreed. This was the development of a set of standardised clinical management tools (forms and associated processes, termed protocols) which would be used by all four sectors. It was believed that this would be more efficient and cost-effective than to have each sector adopting a local interpretation of the guidelines. The guidelines thus came to be seen as the supporting framework for implementation of the standardised protocols. This decision was reached by consensus as the group came to realise that the guidelines might not be implemented in a consistent manner if they were left to local interpretation.

Development of clinical practice guidelines and protocols for mental health intake

The development of the guidelines and protocols occurred in an iterative manner, through progressive modifications to existing documents with first one sector then another taking the lead in introducing a new development for the group to consider. Throughout the process, all members of the steering committee were involved and made multiple changes to each draft. During this process, drafts were also distributed to clinical staff in the four sectors for their expert opinion and feedback. This proved to be a fundamental aspect of achieving commitment to change.

Triage and prioritising access to services

To the committee's knowledge there were no published versions of a community mental health triage scale suitable for intake in a variety of New South Wales community mental health centres. Thus this component of the protocols was developed *de novo.*

It was agreed that three major categories specifying further intervention by mental health services would cover most situations. These were 'emergency' (where a response was required immediately), 'urgent' (where a response was required within 24–48 hours) and 'non-urgent' (where a response could be delayed for days to weeks).

Where emergency or urgency was not apparent, a fourth category was defined. This occurred when insufficient information about the referral was available to determine if public sector mental health services interventions would be required. Thus a category called 'deferred decision' was added. This category implied that staff would seek further information before commencing a mental health intervention plan.

The fifth category was 'referred', where the decision at intake was that alternative service providers were appropriate and available, and that there was no requirement to proceed to comprehensive assessment.

Each category was provided with descriptive anchor points, a recommended response time, and actions to assist the intake clinician in making the most appropriate management decision. As far as possible, the anchor points for the emergency, urgent and non-urgent categories used descriptors similar to those of the Mental Health Triage Scale for emergency hospital departments which was under development at the same time (South Eastern Sydney Area Health Service 1999).

Table 1: Triage categories for community mental health services

Category	Response time	Action
1. Emergency	Immediate response/intervention*	Intake officer notify police/ambulance/ crisis team
2. Urgent	Initiation of management/action plan within one hour*	Intake officer notify police/ambulance/ crisis team/other agencies as indicated
3. Non-urgent	Initiation of clinical follow-up (management plan) within 24 hours*	Intake officer to provide brief counselling/ intervention as appropriate; refer client to most appropriate service
4. Deferred	As soon as practicable*	Intake officer gathers relevant information, determines contingency plan: action contingent on further information or contact
5. Referred	As soon as practicable*	Alternative referral options discussed to referrer/identified client; plan confirmation of referral (appointment made/attended)

* Recommended response time

Intake risk-assessment tool

A simple standardised risk-assessment tool was developed for use with all clients who attempted to access mental health services. It was based on a modified version of the Level of Care Utilisation System for Psychiatric and Addiction Services (American Association of Community Psychiatrists 1997). This was developed by the American Association of Community Psychiatrists as a tool to predict resource utilisation. It contained specific anchor points on a five-point scale which examined:

- risk of harm to self or others
- current level of functioning
- availability of supports
- history of previous response to treatment, and
- assessment of attitude and engagement with treatment.

Modifications were made to adapt the tool for use in South Eastern Sydney Area Health Service community mental health settings.

Common comprehensive assessment process

The steering committee achieved consensus on the format of a standardised comprehensive clinical assessment tool to be used at the point when emergency management decisions were complete and more detailed information to plan either treatment or referral was required. It contained the usual components of psychiatric and medical history, psychosocial assessments, family history, substance use and medical

investigations. It differed from forms that were already in use because it was designed to replace current narrative-based forms, and contained checklists and prompts to assist clinicians in undertaking the assessment. In order to reduce the amount of duplication and to increase clinician compliance, it was agreed that this document would also be trialed as the clinical summary. It will simply be photocopied and sent to the patient's general practitioner or other health professional as the initial written reply to a referral, or for use as a standard clinical practice request for ongoing service when a client is being referred. The protocol also contained prompts to remind clinicians to identify clients who were 'service priorities' such as first-onset psychosis. They also reminded clinicians to commence the recommended clinical practice guidelines for that target group.

Promoting collaborative care with other providers

It was considered important to ensure that all new documentation contributed to the move of the service in the direction of national and State policy, emphasising promotion of collaborative care between general practitioners (and/or other providers) and public mental health services. It was thus essential that both intake and comprehensive assessment protocols contained mandatory prompts for clinicians to contact patients' general practitioners in the generation of the management plan. A template for generating feedback letters to the referrer was also developed for use after the initial triage decision, and another for use after the completion of the comprehensive assessment.

Implementation phase planned

It was decided that the protocols would be piloted in one of the sectors in August 1999, accompanied by an assertive staff training and education program. After this three-month trial period, an evaluation of effectiveness and compliance by clinicians will be undertaken. This evaluation will include measurement of adherence to benchmarks for timeliness of response, adverse-events monitoring and routine health outcome measurement. It is planned that generalisation across the whole Area will then take place. Development of an electronic data base for routine collection of data related to intake is also planned.

Discussion

The process of developing a standardised intake/triage/comprehensive assessment for a whole Area-wide service has been a challenging task. From four sites with different processes at intake the committee achieved consensus on what was important to be included in a single new set of forms. One of the main discussion points was how to obtain the optimum balance between the amount of narrative information (clinician-preferred style) and the number of checklist questions (management imperative to achieve greater standardisation).

Numerous clinical practice guidelines have been developed to assist clinicians in decisions about appropriate health care for specific clinical situations (Field & Lohr 1990). However, guidelines have not been widely accepted among mental health professionals. There have been concerns about the validity and reliability of guidelines. They are often viewed as additional workload and limiting of professional competence. Many view them as a 'cookbook' approach which is not suitable for the delivery of mental health care because mental illness/disorders are too complex and idiosyncratic (Tobin et al. 1998). This project paid careful attention to the engagement of clinicians by its emphasis on achieving a balance between narrative and checklist.

Combining both narrative and checklist approaches in a manageable length of document in order to maximise compliance was a second major challenge. Whether the appropriate balance has been achieved will only be determined during the evaluation phase. However, the process of achieving consensus was essential for instigating the culture change required to reach agreement on the trial phase.

The involvement of the Area Director of the mental health services, service managers, intake clinicians, consumer representatives and a general practitioner were all crucial in ensuring decisions were practical and achievable. Engagement of clinical staff (by providing opportunities to comment on successive drafts of the documents) was also essential. Thus the document went through multiple iterations before it was considered ready for piloting. This process emphasised the importance of continuous feedback and engagement in the development of clinical practice guidelines.

Restructuring a complex and large mental health service involves more than developing and trialing guidelines and protocols. It involves culture change at multiple levels of the organisation, including a requirement for clinicians to move from highly individualistic and autonomous clinical practice to providing a service with greater reliance on standardisation. Past efforts at sustainable implementation of clinical practice guidelines and health outcome measures in the same service had not been highly successful (Tobin et al. 1998). What had been learnt from past processes was the necessity for intensive training and ongoing supervision in integrating the new system within the parameters of the organisation. Importantly the organisation itself must undergo restructuring to emphasise intake and initial assessment by the provision of adequate resources and management support. Thus it was clear to the Area Director and sector directors that emphasising improvements at the intake end of the service would lead to rationing in services for chronic care. Such decisions to change service priorities require national and State policy support, engagement of consumers and referrers, and most importantly a belief that improving intake and assessment would ultimately lead to greater efficiency and effectiveness of the service as a whole. Whilst the first two conditions were present, the third condition will only be determined by evaluation of the new system.

It was anticipated that there would be resistance to the new intake system. Thus, training and education of staff needs to be accompanied by engagement of clinicians in job redesign to ensure they see how the new intake system fits into the larger picture of the organisation as a whole.

The mental health program in South Eastern Sydney Area Health Service has been engaging in clinical practice and organisational change across many aspects of the service. These have included improvement of case management services for young people with first-onset psychosis, people from non-English speaking backgrounds, and clients with mental health and drug and alcohol co-morbidity.

In each of these many clinicians expressed distrust of change itself. It is important that acknowledgement of the need for change to meet the new national and State priorities does not imply that what clinicians were previously doing was less than optimal. Otherwise there is a risk that the process of change will lead to demoralisation and further disincentives to change.

From what has been learned across the multiple clinical practice changes put in place over the past four years in South Eastern Sydney Area Health Service, the attention to detail required in the development and engagement with this change to intake and assessment was considerable. Only future evaluation of the new system will allow us to judge whether it has been successful. What is apparent is that national and State policy changes have profound implications for services and these should not be underestimated.

Conclusion

Within health systems generally, the move towards an evidence-based approach is influential, and is aimed at reducing unnecessary variance associated with clinical experience and intuition. This evidence-based approach aims to encourage forms of clinical practice that do more good than harm (Ahmad & Silagy 1995).

The development of the guidelines and protocols for South Eastern Sydney Area Health Service has potential for further improvement. However, at this stage the development of a standardised gateway to the service is a huge step. Mental health systems are complicated, often discontinuous and are currently in a state of flux. Reorganising them requires a long-term commitment by the whole health sector in which they are embedded.

This must be taken into account when service directors and managers commence implementation of new national or State priorities for mental health. Managing community expectations which may not recognise the imperatives to improve access, restructuring organisations so that new priorities can be achieved, engaging clinicians and maintaining the enthusiasm for change are complex, interrelated tasks. The development of a new intake process represents one paradigm of the scope of change required.

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