Improving clinical management for consumers with co-existing mental health and substance use disorders: an integrated approach

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Abstract

Using Quality Improvement project methodology, complex organisational and clinical practice change was brought about to improve services for people with co-existing mental health and alcohol and drug misuse. The project describes local uptake and adaptation of national and state policy to achieve change that is sustainable within existing resources. Emphasis on engagement of staff and consumers and carers throughout the change was an essential component. The project has implications for the introduction of changes in response to other national policy directives.

The problem of concurrent problems

People who have a concurrent problem of drug and/or alcohol misuse and mental illness are a diverse group, with complex needs and require a range of treatment and support options (NSW Health Department 1998). Service delivery systems often fail to meet adequately the needs of this target group (Burdekin 1993). The terms "dual diagnosis" and "comorbidity" are used interchangeably throughout the literature for this group of conditions. When they are used in this paper they will be taken to mean the more generic term; co-existing mental health and substance use disorders.

There have been policy recommendations at Commonwealth (1998) and NSW State (2000) level recommending integration of service delivery. The Australian National Standards for Mental Health (1996) also emphasise this approach.

Unfortunately, the process of developing integrated service delivery models is often difficult, with multiple challenges. Mental health and alcohol and other drugs (AOD) services often have separate programs, geographical locations, funding, administration and training, hence bringing staff together is not simple.

There may be territorial disputes about who has primary clinical responsibility. There is a lack of consistent inter-disciplinary training, a scarcity of specific programs and differing philosophies of care. The co-occurrence

of mental illness is recognised as making it more difficult for some consumers to comprehend and participate in standard AOD programs (Ridgely, Goldman and Willenberg 1990). Therefore mental health and AOD services must find creative solutions. This report outlines one organisation's move in that direction.

Existing models of service delivery

Three main service delivery models for this consumer group are described in the literature (McDermott & Pyett 1993). The first is the serial model, where the treatment for one condition follows treatment for the other. This model fails when neither mental health or AOD services will commence intervention for consumers because of the co-existing problem.

Second is the parallel model, where the consumer is primarily in the care of one service which liaises with the other for the concurrent treatment of the co-existing problem. This model fails when the primary service is not the more appropriate and when liaison between services is not adequate. Both models have failed to increase the knowledge or skills of clinicians, to promote integration of programs or to safeguard the consumer from receiving conflicting advice from clinicians in either service (Ries 1993).

The integrated model combines the core elements of both MH and AOD treatment into a unified program to meet the concurrent needs of consumers (Ries 1993). This approach requires clinicians from both services to be "cross-trained" in both MH and AOD and the adoption of a unified case management approach. Consumers receive coherent treatment rather than contradictory messages from the two perspectives. Such integrated models exist on a continuum, including 'hybrid models', 'linkages models' or 'fully integrated models sub-specialist' (Jerrell & Ridgley 1995).

A fully integrated model usually occurs via establishment of a sub-specialist team specifically for consumers with co-existing disorders. Despite its apparent simplicity, it has a number of disadvantages.

Increasing the pattern of sub-specialization and segmentation of services for people with mental illness contributes to deskilling a broad range of clinicians who see fewer consumers with complex problems (Rice 1989). The prevalence of comorbidity is so high that such sub-specialist services risk being overwhelmed by the numbers of consumers referred. Third, there are inherent administrative inefficiencies in establishing and maintaining specialist teams (Howland 1990; Teesson, Gallagher and Ozols 1998).

One realistic option for achieving improved cooperation and co-ordination between existing services is the hybrid model based on assertive collaboration between the two different programs. However it poses three challenges for service managers. These are enthusing staff about closer working relationships with others; defining the parameters of successful collaboration and determining the mechanisms which will facilitate it.

One systematic response to such challenges is using a Quality Improvement (QI) approach to achieving sustainable organisational change, (McFarland et al, 1996; Sluyter 1996; Tobin & Chen 1999). The usefulness of this approach stems from its flexibility as the process can be divided into manageable increments of change. (Duck 1993; Troy & Scheuman 1992; Tobin et al 2000).

Organisational context

South East Health (SEH) is one of the major metropolitan Area health services in Sydney, NSW. It services a diverse population of more than 750,000 people. Its mental health program comprises four semi-autonomous operational units (sectors) covering separate geographical districts. Each sector consists of an in-patient psychiatric unit and community based mental health (MH) teams.

The Area also has an alcohol and other drugs (AOD) program which consists of five operational units providing methadone maintenance, needle and syringe exchange, outpatient detoxification, counselling and education. Across the Area there are six inpatient beds allocated for consumers with AOD problems requiring admission.

MH and AOD Services in SEH evolved independently from each other, with separate funding, administration and program mandates. SEH identified the need to develop a more sustainable model of service within existing

resources. With the assistance of Commonwealth Mental Health Reform and Incentive (Transitional) funding, MH and AOD services jointly implemented a two-year organisational development project.

Post-implementation evaluation is only preliminary, but early review findings have been included. The aim of the project was to use Quality Improvement methods to engage both MH and AOD clinicians in the design, implementation and evaluation of a model of care for people with co-existing problems that was sustainable within existing resources.

Methodology

Identification of Stakeholders

A steering committee was established via nominations of directors and managers of the four MH and the five AOD services. Consumer representation was sought through a local consumer consultative committee. A project officer was appointed to assist the project.

Review of current services

The steering committee organised a systematic review of all current policies, procedures and protocols relevant to the topic. The aim was to identify the range of clinical practices in operation, recognise barriers to collaboration between services and foster opportunities for systematic improvement.

Reaching agreement on the parameters for change

The steering committee determined by consensus that the key elements of practice which were priorities for improvement were formalisation of working relationships between services and development of screening tools, clinical practice guidelines and introduction of policies and procedures.

Developing formal relationships

Each local MH and AOD service agreed on the parameters of their improved formal relationship. At one site, this was an improved service agreement which specified timeliness of responses to referrals, and at other sites a range of approaches to improved communication and more sharing of clinical care. The steering committee did not mandate what the improved relationships should be, but only that each site should demonstrate progress from its starting point.

Development of common tools and procedures

Sampling a random selection of clinical files at the start of the project revealed that routine screening for comorbidity did not occur in either service. Therefore consumers were only identified when their problems became extremely complex. Recognition of this led to agreement to develop formal screening and assessment tools to identify all consumers in the target group, not just those with challenging and complex problems.

New tools developed

Screening, assessment and clinical management tools available from other services in Australia and New Zealand and from the published literature were evaluated. The evaluation criteria included practical utility (ie, short format for routine use), ease of use, availability in the public domain, and potential generalisability across different clinical settings. No tools in use elsewhere were entirely suitable for SEH.

Therefore the steering committee developed its own tool based on the Locus of Care Utilisation Scale LOCUS APA (1997). It used descriptors and anchor points which made sense to clinicians. It was accompanied by a flow chart which advised clinicians how to manage consumers with comorbidity.

Obtaining views of clinical staff

At each service site, clinical staff from both programs were organised to attend a joint clinical meeting. The staff selected examples from their consumer group to bring to this meeting for a joint "case study", based on both good and poor outcomes.

These clinical problems were then discussed in a structured case conference format guided and facilitated by the Professor of MH Nursing using a set of common questions at each site. This enabled clinicians to identify both good clinical practice as well as barriers to effective care. It also provided a structured forum for the expression of anger or anxiety about the "other" service. Minutes of each meeting were taken by the project officer and common themes from each group were identified for discussion by the steering committee. Responses from the steering committee were then relayed back to staff at each site.

In addition, each idea generated at the steering committee was fed back to staff for comment. In this way, the tools and procedures received progressive and incremental endorsement.

Obtaining inputs from consumers and carers

With respect to interviewers, advertisements were used to recruit consumers who had past experience with either or both MH and AOD services. A formal selection process occurred and the successful applicants were provided with basic training in facilitating group discussions.

Current consumers with co-existing MH and AOD problems were identified by clinicians and invited to contribute their views on what they had experienced as impediments to best care. A parallel series of initiatives was used to seek the views of carers. Discussions were held separately with consumers and carers, and each discussion was facilitated by the consumer interviewers.

A structured focus group format was used at each site. The consumer facilitators ran the groups, and handwritten notes were taken by a scribe/observer. Transcripts were reviewed jointly by Members of the Steering Committee including the consumer representative. Themes of concern to either consumer and/or carers were identified, collated and provided to the steering committee.

Results

75 clinicians using 15 case scenarios participated in the joint clinical discussions and all staff were consulted about project developments as they occurred. The opinions of 31 consumers and 17 carers were obtained.

Consumer and carer views of services

There were widespread complaints that neither service provided sufficient information about illness or medications and side effects, particularly excessive weight gain, drowsiness, and the impact on school or work performance. Criticisms also occurred about the inappropriateness of acute psychiatric units for many young people experiencing their first episode of mental illness, difficulties accessing services early and the prolonged duration of untreated illness before finding appropriate help.

Some consumers perceived greater stigma associated with MH and preferred using AOD services because substance misuse problems were more socially acceptable. Consistently, consumers and carers expressed a preference for continuity of clinician care irrespective of the service. Both groups complained about the scarcity of inpatient detoxification facilities and inadequate rehabilitation services.

Overnight stays in hospital following episodes of self-harm were deemed too short by both groups. Discharge from hospital after such short stays was associated with reduced chance of establishing contact with appropriate follow-up care.

Contradictory philosophies between services were noted. AOD services were said to encourage harm minimisation and emphasise motivation to change, whereas mental health services encouraged abstinence and often used involuntary treatment options available under the Mental Health legislation (NSW Mental Health Act 1990).

Staff perceptions of problems

MH staff complained that AOD services did not deal with acute suicidal behaviour and did not have an "after hours" response team. AOD staff did not understand why MH services maintained a view that inpatient care was not useful when the consumer was misusing alcohol and other substances. Both groups of staff believed there were insufficient resources available to deal adequately with the large number of consumers in the target group.

Changes during project

These included improved service agreements at each site, collaborative development and implementation of policies and procedures for staff, and introduction of guidelines for practice.

Improving identification and establishing an agreed minimum data set

In keeping with the directions of the Second National Mental Health Plan (1998), both programs moved towards a broader focus than previously and prioritised treatability, preventability and need. Consumers with high risk, high service utilisation or complex health issues were identified as a priority target group. This meant that not every person with co-existing problems who accessed either AOD or MH services needed a totally integrated care package.

Some needs would be met by improvements within one or other service. The triage and screening tools developed enabled staff to channel consumers into integrated care when their needs required this most resource intensive approach.

Cultural and practice change

The newly developed flow chart, screening and assessment tools were successfully introduced, and resulted in a shared approach to care. Agreed language of "co-existing problems" replaced the previous debates about "primary responsibility". The value of harm minimisation approaches was acknowledged for those situations where abstinence was not sustainable.

Joint training programs were developed enabling each service to learn from the other, rather than trying to affix blame.

Discussion

Clinician engagement

This project describes the process of clinician engagement in developing collaborative care and suggests it is both useful and difficult. The implications are that is unlikely that transfers or copying of model service agreements, or imposing policies and procedures, will be effective in themselves. This conclusion emphasises the difficulty of implementing national and state policy at local levels where the capacity of service managers to use an approach such as this may be limited by available time, skills and experience.

Consumer and carer participation in change

Engaging consumers and their carers in any such joint approaches is another essential step. In the course of developing the new model, some consumers felt there was a risk they would be "transferred" to another service, and they expressed disquiet about lack of continuity of care.

Communication of the value underpinning shared or collaborative care is essential to optimise compliance with any system of care change. Unless staff are convinced of this value themselves, they cannot influence consumers. Given the strong national MH agenda to improve MH collaborative care with general practitioners, which may also have the potential to be seen as "rejecting" consumers, this issue has broader implications.

Systems of collaborative care

Transparency of admission criteria is essential for consumers with complex issues of comorbidity and intoxication. Otherwise seemingly unrealistic demands for inpatient care cannot be managed without the appearance of unnecessary and rigid barriers being erected. Even when admission does occur, poor discharge practices especially after overnight or weekend stays contribute to further loss of confidence in service systems.

Engaging staff, carers and consumers in understanding the reasons for an overnight admission is essential. For example, such short admissions may be about ensuring immediate safety but are not generally for the purpose of providing comprehensive assessment and treatment planning. This can usually be done outside hospital.

Culture and attitude change

During this project there was a shift in attitude of staff from both programs. Clinicians began to support the establishment of shared education, joint clinical case reviews, common orientation to both services for all new staff, and strategies to facilitate rotation of clinicians between the two services.

One example of attitude change occurred in AOD services. Previously many clinicians had a preference for a narrative style of clinical assessment which included motivational interviewing and identifying stages of change. The adoption of a semi-structured tool for assessing the risk of a concurrent mental health problem occurred because it enabled clinicians to communicate MH issues appropriately and thereby enhanced the referral process. Another example of attitude change was the acceptance by MH clinicians of the need to adopt a range of AOD clinical management techniques rather than simply trying to enforce abstinence.

Leadership

A project like this, undertaken over two years and involving many aspects of different services, is a significant management commitment. The Area Directors of both MH and AOD made a large investment in time and energy to maintain the enthusiasm of their teams, as a result of which the Steering Committee continued to meet monthly for two years with every member making their time available without fail. Similarly leadership at the individual service level was demonstrated by ongoing commitment of team leaders to the project.

Conclusion

This project demonstrated that it is possible to implement, at a local level, national policy guidelines on shared care for people with comorbid AOD and MH problems.

By using a QI approach, the project became a lever to achieve change across diverse services. Improvements included greater standardisation of clinical practice at the identification and risk assessment end of service delivery, and a more collaborative approach to care.

The resources used for the project were for facilitation of change and not for actual care delivery. This in effect resulted in staff “working smarter”, and additional ongoing resources were not required. Hence the changes have the potential to be sustainable beyond the life of the project.

There are significant challenges in terms of leadership for projects like this. These include management commitment, maintaining energy and enthusiasm over a prolonged period of time and devoting staff time and resources to implementing change.

Whether the changes introduced lead to improved health outcomes for consumers can only be evaluated by a longitudinal analysis over subsequent years.

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