Better Managing Complex Mental Illness in the Community

Delivering Specialised Care Packages, at Scale, through Multidisciplinary Networks of Practice

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Introduction

We have previously illustrated priorities for [reforming primary mental health care](#) in Australia. We have also described [broader reform opportunities](#) to enhance access, overcome inequity and improve the quality of mental health care.

The [evidence is clear](#) that such reforms cannot be achieved by existing workforce and service models alone. Simply growing the workforce or spending more on existing services (largely through increased payments to existing providers) will not be enough. The recent evaluation of the [Better Access Program](#) recommended better targeting of services, to avoid waste and make the most of mental health resources. It recommended for example, that consideration be given to boosting access to ['low intensity'](#) mental health services, so as to free up resources for clients with higher needs.

In addition to this kind of reform, another clear gap in our system's current response to mental illness relates to clients with more complex conditions in the community.

Currently, patients with more complex conditions find it difficult to access the right types of specialist care, at the right time and particularly early in their illness course. These are typically younger people with episodes of illness associated with conditions like bipolar disorder, anorexia, post-traumatic stress disorder or obsessive-compulsive disorder. Many may be 'stuck' in primary care settings receiving repeated assistance from general practitioners or psychologists working alone. Another cohort often attend hospital emergency departments or other public sector acute care services seeking help, only to find those services overwhelmed by other clients with more acute, severe or enduring problems.

As an example here, simply sending a young person with a complex illness to see a psychologist twenty or more times may fail to elicit recovery when instead, they require more holistic care engaging a variety of practitioners. Rather than care from a singleton practitioner, this kind of holistic care in this case may engage a general practitioner, a psychologist, a psychiatrist, a mental health nurse, a dietician, social worker and peer support. This multidisciplinary team might then use a broader range of interventions to provide complex care, including mood stabilizing or antipsychotic medications, brain stimulation techniques, family therapy, complex behavioural therapies and chronotherapy.

Some of this more complex cohort of Australians, having been frustrated with very limited or ineffective prior experiences, may not be in care at all.
[The Productivity Commission](#) included complexity in its definition of a 'missing middle':

> The *missing middle gap* is a service gap encountered by several hundred thousand people who have symptoms that are too complex to be adequately treated by a GP and the limited MBS-rebated individual sessions with psychologists. But their condition also does not reach the threshold for access to State or Territory funded specialised mental health services. Alternative services, such as private psychiatrists or private hospitals, may be inaccessible due to long waiting lists or very high out-of-pocket costs.
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> Productivity Commission Inquiry Report, Mental Health, Volume 1 (2020), p.30

The Commission identified a range of factors creating a barrier separating this complex group of clients from care, including service under-provision, inadequate information, locational mismatches and high out-of-pocket costs. This situation generates colossal costs, both to the individual and their families, as well as to the community and economy more broadly.

This paper presents examples of specific strategies and services to augment Australia's response to mental illness in the community through establishment of Complex Mental Health Care Networks.

These Networks would enhance primary mental health care, giving general practitioners more options than referral to a psychologist or pharmacotherapy. They would also alleviate bottlenecks afflicting the emergency departments of our public hospitals.

Who is this for?

Complex Mental Health Care Networks are designed to meet the needs of a cohort of Australians experiencing mental illness whose needs rarely met by existing Medicare, hospital-based or public acute mental health services. Some may not currently receive mental health care at all. People in this group are likely to have lives significantly affected due to problems associated with illnesses like eating disorders, bipolar disorder, complex anxiety or depressive disorders and comorbid physical and mental health and substance misuse disorders. People facing these complex problems often need access to coordinated, multidisciplinary specialist services, preferably earlier rather than later in their illness course.

We suggest it is possible to build a mini-classification of the clients, arranging them into meaningful, discrete groups, reflecting client need, akin to a Casemix classification system already familiar in the Australian health system. It may be that this mini-classification system contains just a few groups, such as:

1. Complex anxiety disorders (notably Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD)) where there is very significant avoidant behaviour, comorbid episodes of depression or comorbid substance misuse;

2. Complex mood disorders, where there is evidence of poor prior response to conventional psychological or medical therapies;

3. Bipolar disorder, where there is evidence of rapid-cycling, poor response to conventional mood-stabilization, repeated hospitalization or persistent bipolar depression;

4. Eating disorders, where there is evidence of persistent or recurrent illness despite provision of reasonable family, psychological or behavioural therapies; and

5. Neurodevelopmental disorders with comorbid mental health and cognitive difficulties (Autism Spectrum, Attention Deficit Hyperactivity Disorder as adolescents and adults).

What is required?

Meeting people's complex needs has proven beyond the capacity of existing mental health services.

This does not mean those needs are unknown. In fact, for most clients, it is possible to identify a core or preferred set of more specialized assessment, interventions or services. These represent a set of interactions or packages of care that <u>should be</u> provided to enable recovery. For some groups, this set is already well-developed. For others, the component services may evolve further over time as more research is undertaken and preferred treatments become better understood.

Regardless, the Networks offer greater organisation and coordination to complex clients than they get now, a situation which leaves them vulnerable to falling through well-described 'cracks' in our mental health system.

Examples of Complex Mental Health Care Network Packages of Care

Examples of how a Complex Mental Health Care Network might respond to people requiring complex, coordinated mental health care are shown below.

Complex Mood Disorder

Here, specialized assessment and interventions for those with recurrent or persistent major depression that has previously failed to respond to common pharmacological (e.g., SSRIs, SNRIs) or psychological (e,g CBT) interventions can be described and include:

- Extended Specialized Assessment by a Psychiatrist or Clinical Psychologist
- Initiation of a complex pharmacological regimen (combined therapies or augmented therapies)
- Delivery of a complex psychological or behavioural regimen

For people whose mental health does not improve thus far, the following items should also be considered:
- Delivery of a course of repetitive transcranial magnetic stimulation (rTMS)
- Delivery of a novel pharmacological intervention (e. g ketamine, esketamine)
- Delivery of a course of ECT

Complex Bipolar Disorder

People in this situation often require: specialized assessment of the need to commence major mood stabilizing medications – most notably Lithium Carbonate; arranging and reviewing the relevant medical investigations; and, establishing ongoing medical and a mental health management plan. Typically, these processes involve:
- A series of assessment sessions with a psychiatrist to review the option of commencing relevant mood-stabilizing medication;
- Assessment of relevant comorbid mental health (e.g., anxiety, ADHD, PTSD), substance misuse or physical health difficulties (notably, thyroid, renal, cardiac or metabolic disorders).
- Coordination with General Practitioner and other relevant health practitioner (e.g. mental health nurse, pharmacists) the conduct of relevant medical investigations prior to and following commencement of therapy;
- Psychoeducation of service user, family or carers re optimal means of using and monitoring benefits and side-effects of treatment; and,
- Engagement in relevant psychological or behavioural therapies relevant to the optimal use of mood-stabilizing agents, with particular emphasis on sleep-wake cycle management and physical activity.

Mental health Implications of a Neurodevelopmental disorder

Frequently, teenagers and young adults present with mental health or cognitive difficulties as a complication of a pre-existing neurodevelopmental disorder – such as Autism Spectrum or ADHD. While this is often precipitated by the need to obtain documentation for other purposes (e.g., education exemptions, application to the NDIS) or to access a specific treatment (e.g. stimulant medication for attentional difficulties), the opportunity exists for more comprehensive assessment, review of needs for treatments or support and better planning of relevant psychosocial supports. Typically, this involves:

- Assessment by a neuropsychologist for cognitive strengths and difficulties;
- Functional assessment by an occupational therapist or equivalent health professional;
- Assessment by a specialist psychiatrist for review of diagnosis, comorbidities and need for specific medications;
- Provision of information re relevant additional psychological or behavioural interventions; and,
- Initiation and later review of a functional recovery plan.

Specific Anxiety Disorders – Obsessive-Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD)

Well established and disabling forms of specific anxiety disorders (most notably OCD and PTSD) required skilled clinical psychology assessment, access to relevant specific medicines, provision of skilled exposure therapies and relevant psychosocial support. Typically, these include:

- Specialized assessment by a clinical psychologist as to the primary diagnosis, lifetime trajectory, comorbidities and nature of ongoing impairment;
- Review by a psychiatrist as to the relevance of concurrent pharmacotherapy;
- A course of well-supervised exposure therapy, making additional use of other relevant health professionals (notably, mental health nurses); and
- Development of a functional recovery plan and psychosocial support.

Drawing on existing evidence, and focusing on the delivery of time-limited, identifiable, specialised, staged multidisciplinary care, a suitable panel could design this kind of preferred 'package of care' for each of the client groups described in the complex classification system. They may choose to split each group into higher and lower needs as necessary.

We understand that people's needs are individualised and that these packages represent, at one level, a type of preferred average level of care. Some people may require less 'service' than recommended, others more.

Getting into (and out of) the Complex Care Network

Consumers with complex needs could enter the system through several doors, including their general practitioner, the Primary Health Network, head to health, headspace, the emergency department or via the local public acute mental health service team.

The complex care network would provide comprehensive assessment of the person's needs and allocate them to an appropriate package of care.

Recovery from Complex Mental Illness in the Community
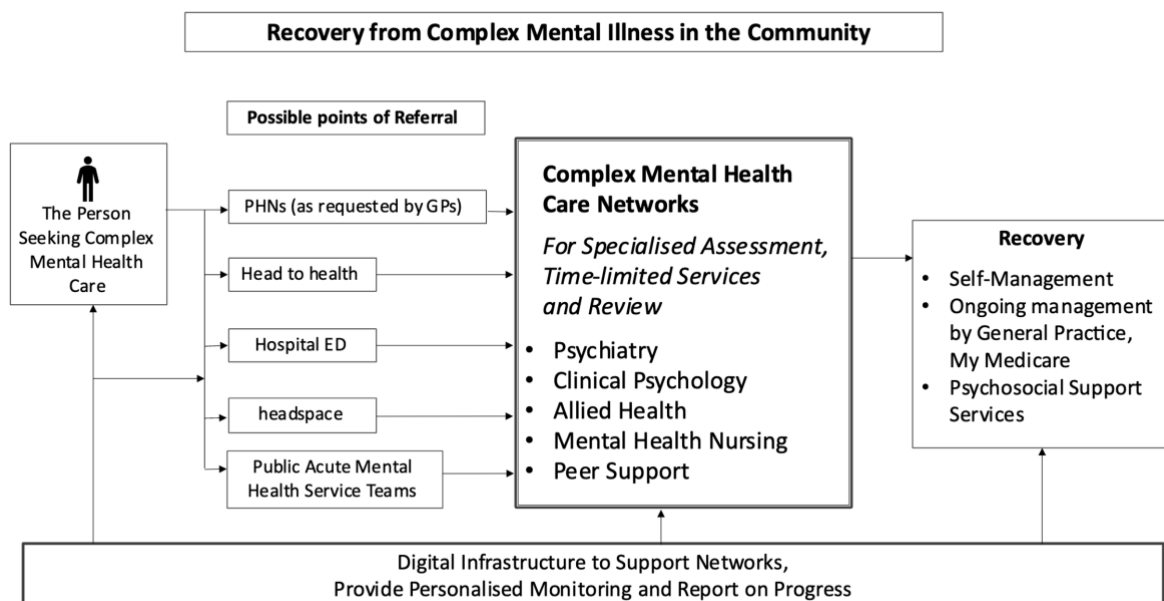
As a result of the package of services provided by the Complex Mental Health Care Networks, the person improves sufficiently to then receive ongoing management in primary care or some psychosocial support, particularly in relation to education, employment, housing or other vital services. Tools to monitor ongoing recovery and enable ongoing self-management would also be important.

The Networks do not offer ongoing care. They offer time-limited, identifiable, specialised, multidisciplinary packages of care designed to help people in their individual journeys of recovery.

Personalised Monitoring

While better planning, funding and a more organised response to mental health complexity is predicated on grouping people together by services packages and costs, it also depends on a new, individualised approach to monitoring and tracking. Consumers would join a network where their individual use of services is recorded, together with an assessment of the impact of service on meeting the person's needs. Decisions about what to do next, in the advent a person's mental health improves or declines, can then be made in the context of their overall package of care. This means providing timely feedback on progress to both the consumer, their carers, and to service providers. There are already examples of this kind of technology, which includes linking consumers to e-health services as part of their ongoing care.

Funding and Commissioning

As with the service types themselves, much too is already known about the cost of care. Using time as a proxy or direct costs where they are available, a large proportion of total service costs for each client group could already be calculable. Where there is technology or other similar non-human element to care, again it is likely that some of the associated costs of delivering these services would already be known or could be estimated. Over time, the costs associated with providing care to each client group, and the services to be provided, would become further refined. The absence of exact cost data now should not preclude progress.

Armed with costed 'packages of care', it would be possible to commission a range of competent providers from public, private, community or other sectors to establish the Networks. Gaps in the provision of care to people with more complex mental health needs occur right across Australia. Wherever providers can be organised into networks to deliver these packages of care, they should be encouraged.

The task of commissioning for complexity could be given to Primary Health Networks, which already commission mental health services from public, private or community providers. The key would be to commission organisations with the capacity to deliver the requisite packages and Networks. Again, this has been done previously in mental health, through PHNs, in relation for example to the delivery of services under the Partners in Recovery Program.

Opting In

Many mental health professionals are aware of their current inability to meet the needs of this more complex client group. Existing service and funding structures limit their capacity to respond effectively. And of course, many consumers and their families daily face the consequences of poor quality care. This proposal would see 'opt in' arrangements for both consumers and professionals. The impact of opting in would be to trigger different payment arrangements to providers and consumer and provider agreement to participate in the personalised monitoring and reporting.

Workforce Impact

As stated earlier, using the existing workforce under existing work structures will not elicit necessary reform and change in mental health. New structures are needed.

In addition to meeting the needs of professionals who wish to work outside the confines of fee for service payment, the proposed Networks may also make use of existing workforces, and new training workforces, more efficiently.

With formal organisation into teams, properly funded, the Networks could become a preferred operating model for many professionals. They offer an opportunity for psychiatrists and clinical psychologists who may be working now with this client group to share the load with others, including those training in their particular speciality. This is because many of the interventions to be designated for each package of care can be effectively provided by a wider variety of workforces, working under supervision of specialist team leaders. Notably, mental health nurses can deliver or oversee many of the medical and physical therapies, while psychological training workforces can do the more complex psychological therapies, with other key roles for occupational therapists, social workers, pharmacists and physiotherapists.

Conclusion

This proposal groups people with complex mental health needs together for the purposes of arranging preferred packages of services, underpinned by personalised monitoring and tracking. In doing so, it aims to address a significant proportion of the 'missing middle' of Australian mental health care.

It fits with Federal Government commitments to foster innovation in primary care. There are also clear links to overall need to bolster the capacity of the psychosocial network, particularly for clients outside of the NDIS.

This proposal will require cooperation between the states and the federal government, not least in relation to funding. It is hoped that the Complex Care Networks would contributed to easing the burden on hospital mental health emergency department presentations, and also help refocus the Better Access Program towards its original client group.

Contact

Dr Sebastian Rosenberg

Professor Ian Hickie

Brain and Mind Centre

University of Sydney

94 Mallett Street

Camperdown

ian.hickie@sydney.edu.au

sebastian.rosenberg@sydney.edu.au

sydney.edu.au

THE UNIVERSITY OF
SYDNEY