Far West Mental Health Recovery Centre: a partnership model of recovery focused mental health inpatient care

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Abstract

This is a brief preliminary report on the model for a partnership between a public mental health service, Far West Local Health District, and Neami National, a Community Managed Organisation, to provide recovery focused subacute mental health inpatient care in remote Australia. It describes early activity data and focuses on the workforce model that makes the service cost effective and sustainable in a rural location. It is targeted towards health service managers and policy makers to facilitate context specific transferability.

Background

Far West Local Health District (LHD) covers an area of 90,000 square kilometres in outback New South Wales (NSW) Australia. Most of its 30,000 residents live in Broken Hill (18,000 people) or along the Murray River that forms the southern boundary of the LHD (10,000 people). Several small towns and a number of large rural properties are home to remaining residents. Broken Hill is three hours from the nearest town of any size, Mildura (population 30,000), and fourteen hours' drive from Sydney, the NSW capital. It is closer in distance, time and cultural alignment to South Australia. Far West LHD is the most sparsely populated LHD in NSW and has the highest proportion of Aboriginal residents (9.6%) (1).

The District has an integrated Mental Health and Drug & Alcohol (MHDA) Service consisting of a six bed acute Mental Health Inpatient Unit, two adult Community MHDA Teams that provide intake, crisis care and case management in business hours in two of the most populous regions, a Child and Adolescent Mental Health Service (CAMHS) outpatient service and a Magistrates Early Referral Into Treatment (MERIT) drug and alcohol court diversion service. The more remote sites are serviced by an MHDA team operated by the Royal Flying Doctor Service (RFDS) and the Maari Ma Health Aboriginal Corporation's Social and Emotional Wellbeing Team. The Mental Health Emergency Care – Rural Access Program (MHEC-RAP) (2), based in another LHD, is contracted to conduct mental health triage and assessment via videoconference in the remote towns and in Broken Hill Emergency Department outside business hours. Several Community Managed Organisations provide community support to people with high level mental health needs as an adjunct to case management.

Prior to the opening of the Far West Mental Health Recovery Centre, the MH Inpatient Unit was frequently fully occupied and it was not unusual for mental health patients to overflow into the adjacent medical ward. Others had to be transported to a large psychiatric hospital in Orange. The journey from Broken Hill to Orange is one and one half hours flight by the RFDS or a 10 hour drive. This meant that many mental health patients were receiving sub-optimal care or were out of touch with their families and community for long periods of time (3-5).

As in many rural areas, recruitment and retention of clinical staff for the MH Inpatient Unit was difficult (6). At the beginning of 2011, the 12 strong workforce of the MH Inpatient Unit had only 50% permanent staffing. Agency nurses that stayed for periods of three to six months made up the remainder of the workforce. This transient workforce prevented a cohesive model of care and, due to agency fees of approximately $1000 AU per week, was expensive to maintain.

Commonwealth funding for sub-acute mental health inpatient care offered an answer to the chronic bed shortage (7). It also addressed a local need for mental health organisations to work collaboratively to provide early intervention to prevent deterioration into severe mental ill health (8, 9). The funding guidelines were flexible enough to allow non-traditional public inpatient mental health care, i.e. care that is provided by people other than nurses and allied health clinicians. Similar initiatives have been utilised in the USA to address rural health workforce shortages (10).

Far West Mental Health Recovery Centre Model

Modelled on Prevention and Recovery Care (PARC) units (11), the 10 bed Recovery Centre is the first inpatient unit to be operated and staffed by a Community Managed Organisation in New South Wales (NSW), Australia. This model makes the service sustainable in a rural environment, both because it is cost effective and because it relies on a non-professional workforce of local residents to deliver care.

Under the adapted PARC service model, the Recovery Centre offers participants residential care for up to six weeks duration. Participants requiring additional mental health support when they begin to show signs of mental ill health can enter the Recovery Centre directly from the community (known as step-up care). People who need additional recovery time can be transferred from the MH Inpatient Unit (step-down care). Because the Centre supports an early intervention approach, it has a target of 60% step up care.

Architecturally, the Recovery Centre represents a significant shift from the traditional institutional mental health inpatient unit. Its modern design blends with the outback environment and is integral to the recovery model of mental health care practiced within. It is a space that makes a person feel valued, important, welcome and safe, all domains of the National Framework for Recovery Oriented Mental Health Services (12).

The roles of the LHD and the Community Managed Organisation in the partnership are defined in a contract based on the activity of the unit. Far West LHD owns the Recovery Centre building and its contents. It is responsible for maintenance, repairs, electricity and laundry costs. The Community Managed Organisation, Neami National, is responsible for staffing the service and providing recovery focussed, strengths based programs to participants. It has its own clinical governance and incident management systems and covers the costs of food, petrol and similar operating costs.

There is no psychiatry coverage to the Recovery Centre. When residents require psychiatric assessment or review, they attend appointments at the adjacent Community MHDA Service.

Because Neami National employs a workforce of Rehabilitation and Support Workers (RSWs) and Peer Support Workers (PSWs), the Recovery Centre does not need to rely on a short supply of mental health clinicians or expensive agency staff. It employs local residents with both professional and non-professional backgrounds who are recruited primarily because of their personal values and ethics. They are supported by extensive training in the Collaborative Recovery Model (CRM) of mental health care, additional education as needed and an on-site Senior Mental Health Clinician employed by the LHD (13).

It has previously proven difficult for Community Managed Organisations in remote NSW to function effectively without local management. When local services need to defer to a manager in a distant location who visits infrequently, decisions are delayed or may not be appropriate to local circumstances. Also, there can be a gap between the mission of the Community Managed Organisation and the way that mission is interpreted and practiced locally. Because of these potential pitfalls, Neami National provides an on-site Manager and Senior Practice Leader who are supported by training and frequent visits from regional and state managers. In addition, the on-site manager attends regular meetings with the Far West Mental Health and Drug and Alcohol Directorate to ensure the smooth running of the centre to optimise patient outcomes.

The Senior Mental Health Clinician is critical to the success of the model. The clinical expertise and experience, both in mental health care and in the health service itself, are an important resource to the non-clinical staff. Since this position was introduced, the confidence of those working in the Recovery Centre grew; consequently they were more able to accept consumers with more complex conditions into the program.

The workforce model is a major innovation in mental health care in the rural environment. It allows access to a previously untapped local source of staff and is both cost effective and sustainable. It also helps the LHD increase its status as a good citizen through providing a new source of employment and skills training in a town with declining opportunities. The Community Managed Organisation has a standardised quality improvement system across all its sites. The contract between Community

Managed Organisation and the FWLHD specifies performance indicators and regular reporting to ensure quality of services.

Method

Study data was derived from a centre activity data base from March 2013 until June 30 2014 and Neami National evaluation data. The centre activity data base contains the identifying details of participants, referral source, demographics and dates of admission and discharge. This data has been de-identified and aggregated for this paper.

Key Performance Indicator information, such as the 28 Day Mental Health Readmission Rate, has been derived from monthly health performance reports. These reports are password protected and available on the NSW Ministry of Health website.

The NSW Non-Acute Benchmarking Indicators of Good Practice Audit (2014) is an 80 item self-audit of standards for non-acute inpatient mental health care produced by the NSW Ministry of Health and distributed to LHDs (14). The Recovery Centre participated in the audit for the first time in 2014.

The model description is derived from the contract between Far West LHD and Neami National.

The cost of beds in the MH Inpatient Unit and Recovery Centre was calculated by dividing the annual budget for the units by the number of beds. Occupancy rates and the cost of RFDS transfers were not taken into account, nor were the salaries of the Senior Clinician or psychiatrist.

Information about Recovery Centre staff was obtained from Neami National's Human Resource Department.

Findings

Workforce statistics collected by Neami National showed that only two of the 23 people employed in the Recovery Centre since it commenced operation were relocated from another area to work in Broken Hill; the remainder already lived in the town. Three staff members identified as Aboriginal or Torres Strait Islander. Their occupational backgrounds before they commenced employment are wide ranging, with only nine having previously worked in health or community welfare services (**Table 1**). Employee skills improvement was evidenced through certificates achieved: Child Safe Environments – one; Coaching for Managers – two; Senior First Aid – 14 and Suicide Intervention – 18. Qualification levels of Neami employees are detailed at **Table 2**.

There were 183 admissions involving 126 consumers to the Recovery Centre in the two years from March 2013 to March 2015. Of these, 18% identified as Aboriginal or Torres Strait Islander (72% did not identify as Aboriginal or Torres Strait Islander and 10% did not specify Indigenous status). The gender breakdown was very close to even (51% female and 49% male) and most fell between 25 and 54 years of age.

Since the Recovery Centre opened, its occupancy has risen to 73% in the last quarter 2013-14. More significantly, the occupancy rate of the MH Inpatient Unit has dropped from 87% in the first quarter 2011-12 to 62% in the last quarter 2013-14 (**Figure 1**). Overflow admissions of mental health consumers into medical beds in Broken Hill Base Hospital reduced significantly over the period (**Figure 2**) and there were fewer transfers to other hospitals (**Figure 3**).

The average Length of Stay (LOS) for participants was 29 days and the median LOS was 27 days. There were 167 recorded referrals, 72% of these were Step Up referrals and 28% were Step Down exceeding the target of 60% Step Down. Referral sources are detailed at **Figure 4**. 28 Day Mental Health Readmission rates to the MH Inpatient Unit dropped significantly since the Recovery Centre opened and are now below the NSW benchmark of 13% for the 2013-14 financial year (**Figure 5**). The order of primary diagnoses in consumers of FWMHRC was depression (55%); schizophrenia (17%) and bipolar disorder (13%) as shown in **Figure 6.** Almost 75% of Recovery Centre consumers have only used the service once, 14% come back for a second entry, 6% for a third entry and just under 5% of consumers have re-entered between four and seven times (**Figure 7**).

Table 1: Occupational Background Neami National Employees *

Occupation	No employees
Admin, Finance, IT, Management	4
Community and Welfare Services	5
Health and Medical	2
Public Sector	1
Retail, Sales, Hospitality	1
Student	1
Trades, Services, Logistics	1

* including employees who have terminated

Table 2 Qualification Levels Neami National Employees*

Qualification Level	No employees
Post Graduate Degree	
Philosophy & Theology	1
Business and Management	1
Post Graduate Diploma / Certificate	
Psychology	1
Bachelor Degree	
Marketing & Promotion	1
Sociology	1
Psychology	1
Diploma / Associate Diploma	
Psychology	2
Business and Management	1
Certificate IV or less	
Human Welfare Studies and Services	5
Indigenous Studies	1
Computing	1
Nursing	1
Law and Criminology	1

* including employees who have terminated

The Recovery Centre is a more cost efficient service model. The unit bed cost in the MH Inpatient Unit, including the cost of psychiatry (0.5 FTE is attributed to the MH Inpatient Unit), in 2013-14 was $294,333 compared to the unit bed cost in the Recovery Centre of, including the cost of the Senior Clinician (1 FTE), $146,500. The savings associated with reduced RFDS transfers (estimated at ~$5000 per transfer) is approximately $35,000 per annum. Estimated net savings in 2013-14 was therefore $182,833.

The NSW Non-Acute Benchmarking Indicators of Good Practice Audit (2014) indicates the Recovery Centre is meeting 90% of relevant targets. These targets are based on the standards outlined in NSW and Commonwealth policy documents, plans and framework (14).

Figure 1 MHIPU and FWMHRC Occupancy by Quarter from 2011/12 – 2013/14

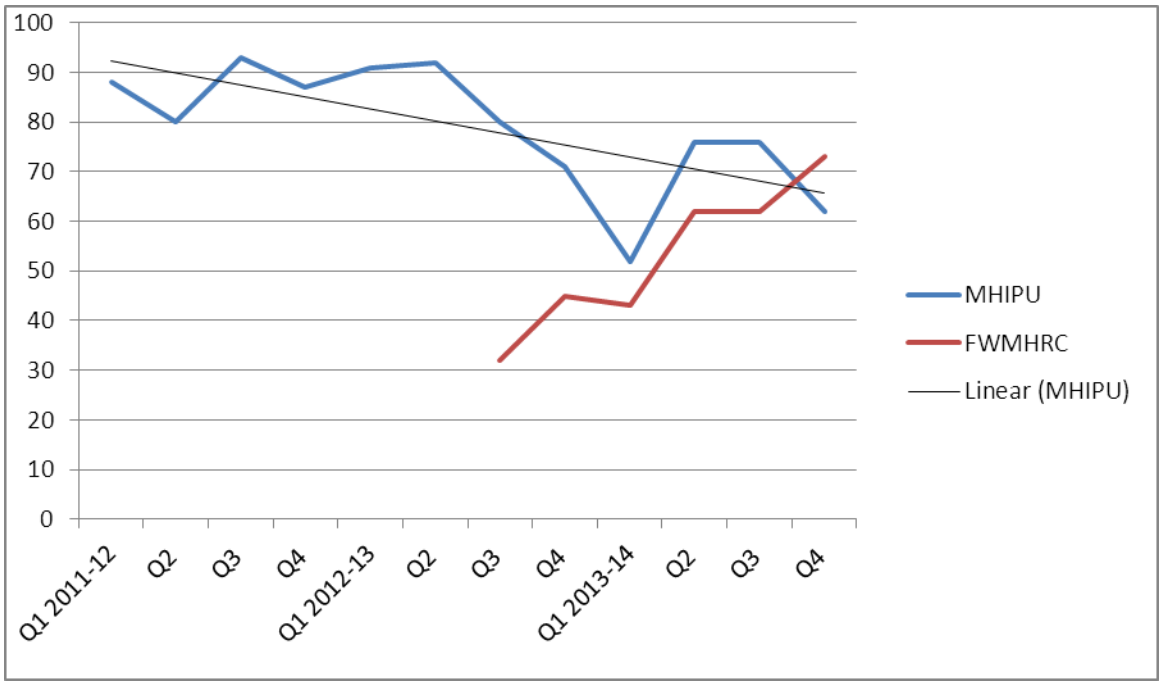


Figure 2 Psychiatry Discharges Broken Hill Health Service 2011/12 - 2013/14 (excluding paediatrics and ED)

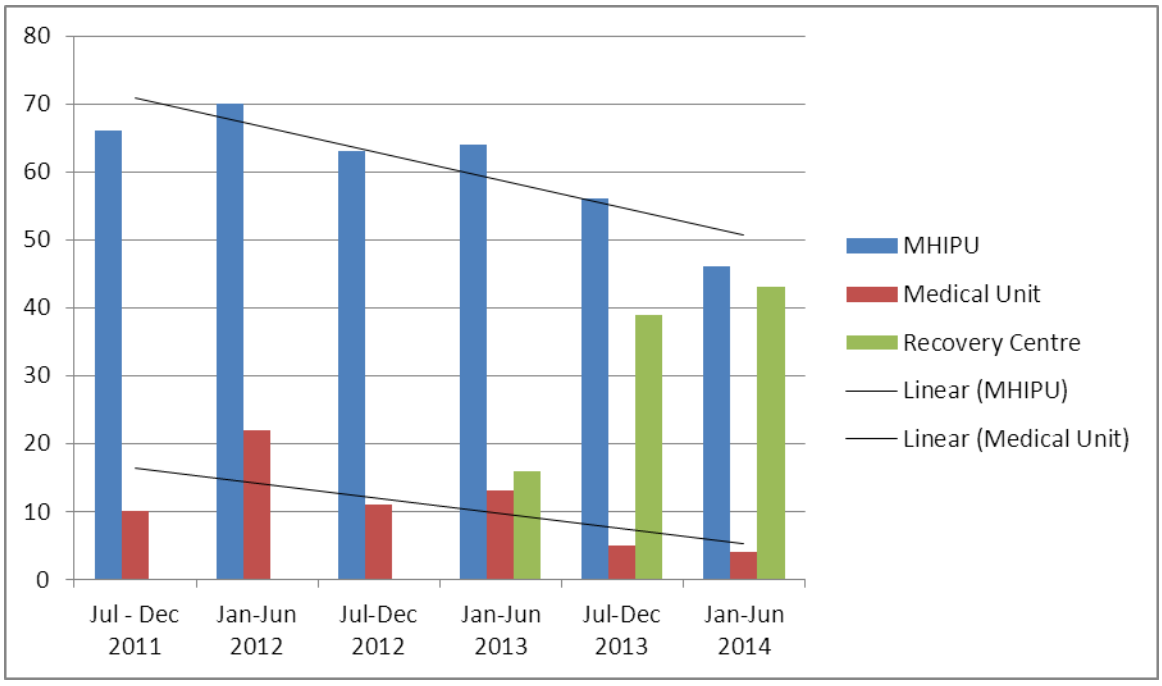


Figure 3 RFDS Transfers from MHIPU 2011-2014

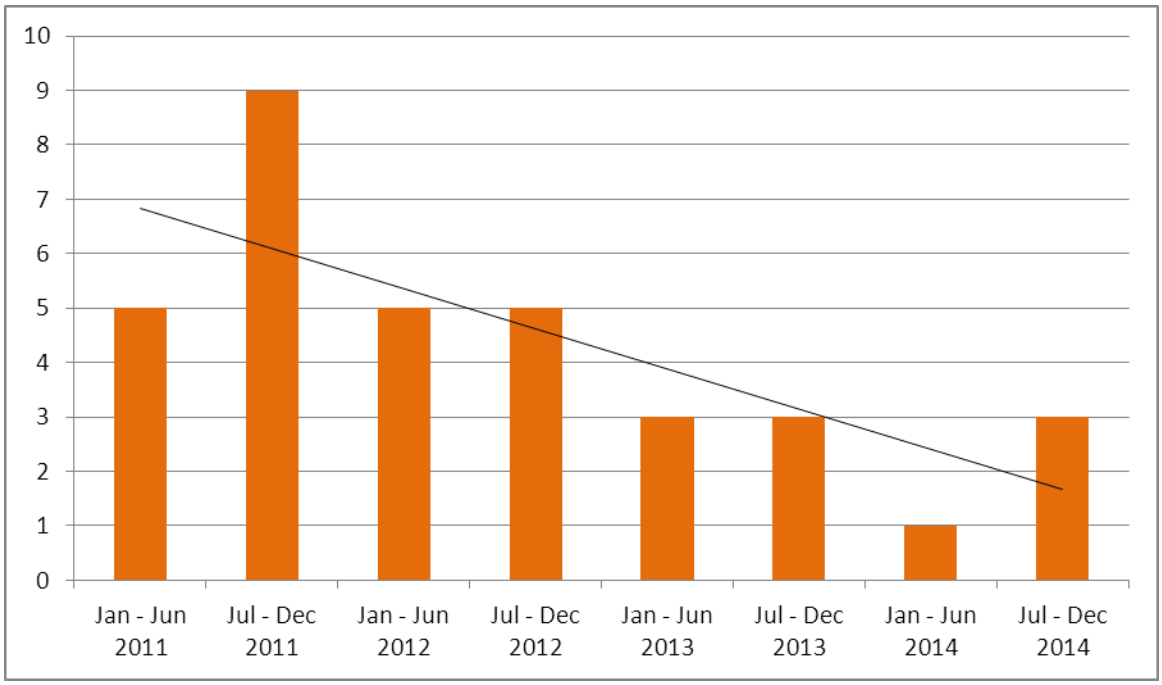
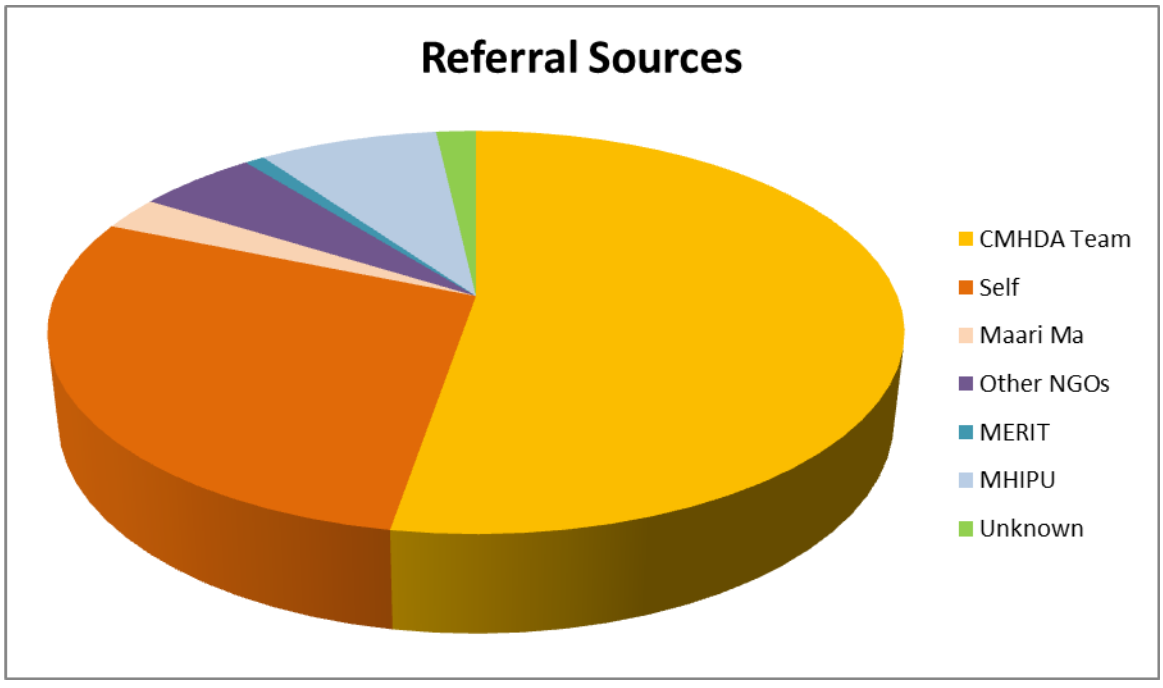


Figure 4 Referral sources



Maari Ma = Aboriginal Health Cooperation

Figure 5 28 Day Acute Mental Health Readmission Rate 2012/13 – 2013/14

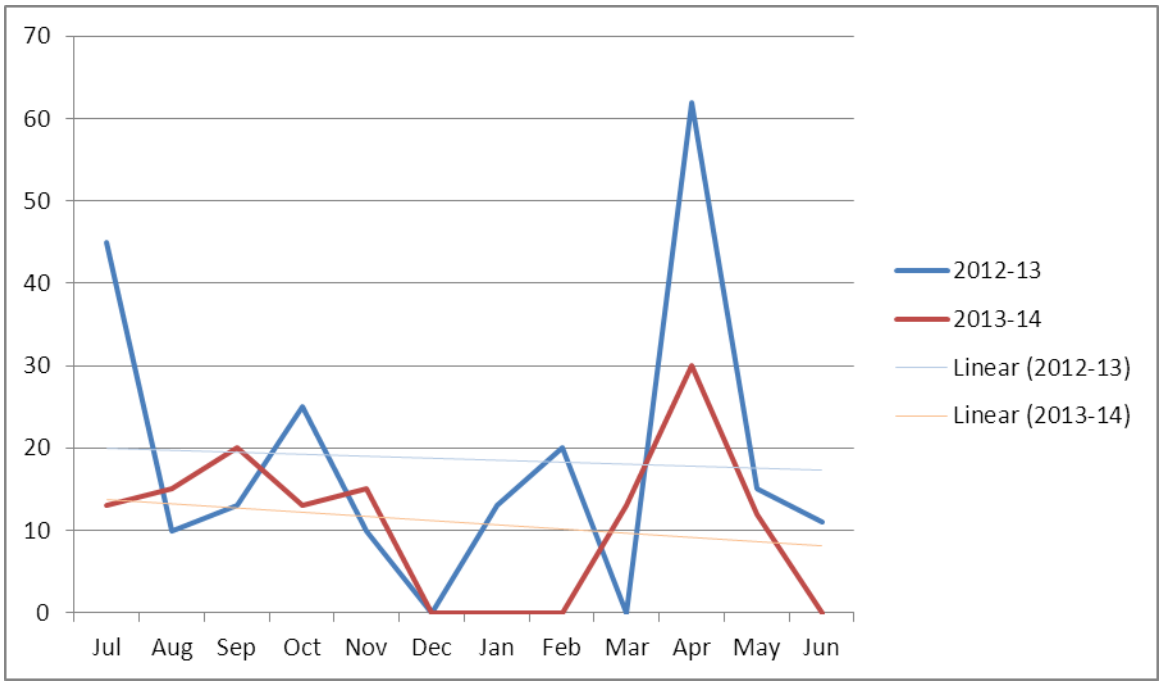


Figure 6 FWMHRC Client Primary Diagnosis

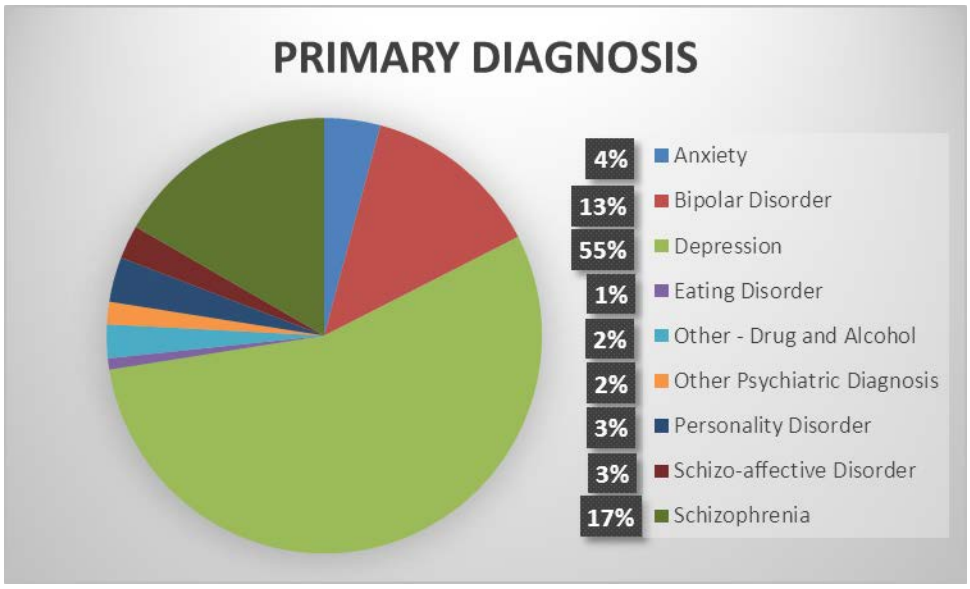
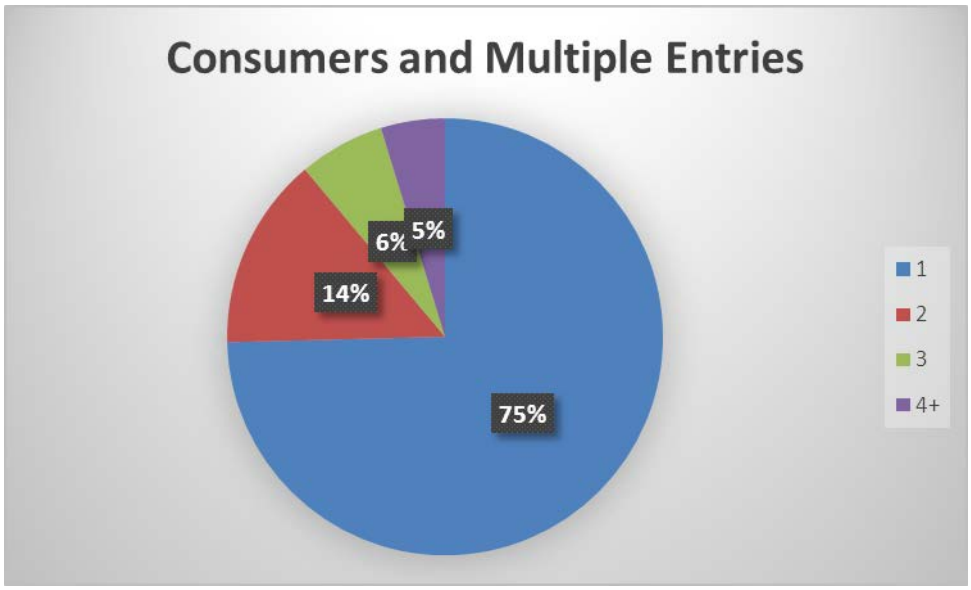


Figure 7 FWMHRC Readmissions



Discussion

The provision of mental health services by the non-government sector is increasing. The Australian Department of Health reported that about one third of Australians living with psychotic illness receive care from non-government organisations with high levels of patient satisfaction (15).

High percentages of self-referrals and direct community admissions combined with lower occupancy rates of acute mental health beds indicates the Recovery Centre is successfully providing early intervention to prevent deterioration into mental ill health. That this can be achieved at a lower cost than inpatient care provided by clinical staff is evidence of the model's success. The observed number of consumers who use the Recovery Centre frequently can be interpreted as convincing evidence of the service acceptability.

Early intervention is also evidenced by the high proportion of admissions who were people not being case managed by the Community MHDA Team and who may not have sought treatment or assistance from a more traditional mental health service for mental distress. Included in the self-referrals were some carers of people living with mental illness, a group that has a high rate of mental distress with a low rate of help seeking behaviour (16).

While the prevention of mental ill health is a desirable outcome for patients, the resultant low occupancy rate of the MH Inpatient Unit is not necessarily a desirable outcome for the LHD. This is because inpatient health care in Australia is funded according to activity (17). In this instance, the reduced activity in the MH Inpatient Unit will attract less funding, providing a perverse incentive for good performance.

The workforce reports from Neami National indicate that, while some employees have a background in health, many come from a broad range of professional and educational experience. Combined with evidence that the substantial majority of this workforce was drawn from the local community, it indicates that the model taps into a new source of mental health workforce in the area. The contribution to the Broken Hill community is significant not only in terms of services to consumers, but also in impact on the economy and skills bank.

The MH Inpatient Unit is operated by two Registered Nurses on each of three shifts. As this is the minimum number of staff required to safely manage the unit, the number of staff cannot be lowered when there are fewer than the full complement of six inpatients. Standard efficiency measures such as bed closures are ineffective because they would not result in the need for fewer nursing staff. The diseconomies of scale in a region with a small population mean the cost of the MH Inpatient Unit remains the same while its activity related funding source is diminished. The financial risk this imposes on the LHD could potentially weigh against the model's transferability in a similarly small

community. A larger feeder population would overcome these diseconomies of scale. In consideration of transferability of the Recovery Centre model, the local footprint context must be taken into account (18). A perverse interpretation of the diseconomies of scale is that the model may be more applicable to communities with larger populations.

Limitations

As the Recovery Centre has been open for a relatively short period of time, little activity data is available. When the model is more mature, further reports will be possible to demonstrate its long term viability.

Further Participatory Action Research (PAR) on focusing on the role of the LHD employed Senior Clinician in the Recovery Centre would be useful to determine their value in the development and maintenance of the relationship between the partner organisations. PAR models have proved effective in the generation of knowledge about how partners from different workplace cultures work together and bring about change to improve patient outcomes (19, 20).

Conclusion

The Far West Mental Health Recovery Centre, as a model of mental health care, based on collaboration between a public mental health service and a Community Managed Organisation, is both successful in its aim of early intervention and in its cost effectiveness. It is a model that can be transferred to other locations on the proviso that there is sufficient population to ensure appropriate levels of bed occupancy.

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Presenters

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