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Streaming Mental Health Consumers Based on Clinical and Psychosocial Needs

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Abstract

The challenge for mental health services is to ensure that available resources are able to meet the needs of mental health consumers. It is useful to develop a staff resourcing model that is based entirely on the identification of mental health needs of consumers. Such a model has the potential to ensure that available mental health staffing resources are not wasted and mental health consumers receive an appropriate level of mental health support.

Introduction

Various models of case management have evolved to meet the needs of mental health consumers who are acknowledged to have complex, varying and diverse needs. These needs range from mental health needs and care of their physical health, to psychosocial care provision for those whose mental disorders interfere with their personal, social and occupational functioning. The primary function of most case management models is to ensure that care, support and treatment provided to mental health consumers are comprehensive and well-coordinated.

Over the last half century, a number of variants of case management have been tried to meet the needs of people with mental health needs. Assertive Community Treatment models were embraced by a number of mental health services to deliver treatment, support and rehabilitation services to individuals with the most intractable symptoms of severe mental illness and functional impairment[1-3]. Further variants of ACT evolved, including Training in Community Living, the Program for Assertive Community Treatment (PACT), Continuous Treatment Teams, and Intensive Psychiatric Community Care. Where the requirement was more to coordinate provision of mental health support or to broker services, other variants of case management emerged. These included brokered case management and clinical case management[4]. With the advent of managed care, case management did take up a whole new meaning and was seen as a way to restraining cost, managing oversupply and utilisation reviews[5].

Different models also seem to have evolved to solve operational issues within provider units, which may also be the reason why different case management models appear to be focussed on managing diverse operational challenges, including managing consumer allocation to mental health professionals within a team, redistribution of workload, gaining more funding, enhancing mental health service workers acceptability of providing care in

the community, resolving inter-agency conflict, etc. In almost all of these variants, the two core principles of case management, i.e. coordination of care to ensure continuity of care and ensuring access to appropriate care and support, are not lost[6,7].

An added benefit of case management models has been that accountabilities for case provision within the mental health care system have become clearer. The introduction of case management has meant that specific agencies are designated the task of coordinating care and treatment to the mental health consumer. In some systems, the case manager has become an identified person with this accountability[8].

The Planning and Coordination Challenge for Mental Health Services

In the mental health field, it is not unusual for the demand to outstrip available resources. To ensure mental health operations remain cost-effective, two basic case management programme models have been tried.

One model developed in Madison, Wisconsin (developed by Stein and Test) involves the delivery of mental health and support services in a programme characterised by the intensity of service, very low caseloads and a multidisciplinary team structure. This model targets people with severe mental illnesses who are frequent users of Emergency or Inpatient services who frequently do not follow through with aftercare plans. This model combines the functions of case management with the provision of clinical services. Therefore the case manager is expected to provide therapies as well as arrange vocational, educational, recreational, legal and family services[9,10].

The second model has focused on coordination of services provided, rather than the delivery of mental health services. In this model a "case management team" that provides a coordination function is often organisationally separate from the "local mental health service delivery team" that provides direct care. This model can be described as `care co-ordination model of case management.' In this model, case managers may still utilise clinical or therapeutic skills in delivering case management services, but the distinction is that although case managers teach new information or skills and help consumers to develop new patterns of behaviour in the course of their relationship, provision of direct services such as counselling, psychotherapy or medication management are not performed by the case manager but by a different treatment programme.

The reality of mental health service provision also is that there are mental health consumers under regular care of the mental health team who have ongoing mental health care needs, but can self-manage. Their level of functioning does not necessarily require a considerable investment of resources in case management (model 1 above) or care coordination (model 2 above). For purposes of this discussion, it may be appropriate to describe this as `key worker model.' In this model a mental health professional is an identified key contact for the mental health consumer and promotes the consumer's independence, resilience and self-management, without necessarily having explicit responsibilities and accountabilities for case management or care coordination.

Effective Streaming of Staffing Resources Based on Consumer Needs

To ensure that staffing resources are allocated to meet consumer needs, it is important to first define the characteristics of the target population for each of these three groups. The following segregation into three streams would be helpful for services developing a structure to provide case management, care coordination and key work services.

When selecting consumers for streaming across the following three groups, age, gender, racial and ethnic characteristics, as well as type, severity and chronicity of illness should be important considerations.

Consumers who need case managers

This group includes mental health consumers with high needs who need to be comprehensively supported. Consumers who are frequent users of emergency services, experience frequent relapses and re-admissions, those who are at risk of non-compliance and those for whom aftercare is problematic, should be included in this group. Essentially, for people in this group, services need to be "individualised" to meet their specific needs.

Consumers who need care coordinators

The second group should be for clients who are high users of services, but their predominant needs are psychosocial. For these clients, care coordinators may be needed. The emphasis here has to be on "coordination" of services that are provided by other service providers or agencies.

Consumers who need key workers

The remaining consumers who need to be in contact with Mental Health Services can be followed up by a key worker.

The most significant benefit of differentiation between the case manager, care coordinator and key worker is an improvement in the efficiency and effectiveness of the service. For example, for case management, staff to client ratio can be 1:10 to 1:12. Somewhat lower staff to consumer ratio should work for those consumers who need care coordination, perhaps 1:15 to 1:20. For key working, the staff to consumer ratio can be as low as 1:25 to 1:30. Although all

care must always be multidisciplinary, more mental health nurses than other mental health disciplines could be case managers, owing to the need for a high level of mental health nursing intervention, including psychotropic medication management for this group of consumers. Care coordinators could predominantly be social workers and occupational therapists as the predominant clinical need of this group of consumers are likely to be psychosocial. All mental health disciplines can be represented amongst key workers.

The decision to develop case management, care coordination or key worker arrangement has to be dependent on the characteristics of the target (consumer) population. If the majority of consumers have needs for casework (or in other words need key worker input), however a care coordinator or case manager model is introduced, the system is likely to become expensive, and in time become unsustainable. On the other hand, if target consumers are mental health consumers with major mental disorders and complex needs, they would require the development of specific therapeutic or recovery needs, assessment of their needs, strengths and recovery goals and determination of desired outcomes. In such a scenario, case management and care coordination-type arrangements may best serve the needs of this consumer group.

Determining caseload size by the number of clients in the service, rather than their clinical care and support needs, is not appropriate. If the correct balance is not achieved to match staff availability and consumer needs, caseload size can become stretched. If caseload size becomes imbalanced, it results in staff burn out and results in high staff turnover. As a result, continuity of care suffers. The model cannot be sustained, and people very quickly become disenchanted. Rather than blaming the way the model is implemented, the structure and functioning of the model itself are then questioned. Therefore, it is important to develop some utilisation review criteria and processes so that any unnecessary services can be eliminated.

Conclusions

Community mental health services often feel stretched. Across the world, the demand for community mental health services seems to be increasing exponentially. Often availability of staffing resources is not able to keep pace with this need. It is important that community mental health services improvise and adjust their model of care optimally to get the most out of available staffing resources.

Mental health consumers have diverse needs. Various variants of case management models have been incredibly useful to ensure that the needs of mental health consumers whose level of functioning has deteriorated as a result of their mental disorder, are met. In the current community-based model of care, it is really important to differentiate consumer groups and identify whether there is a need for case management, care coordination or casework and allocate resources accordingly.

An arrangement that streams mental health clinicians into case management, care coordination and key work streams is likely to be an effective and efficient model to meet the needs of the mental health consumers and their families. It is really important that people with high mental health needs who are struggling to cope with their symptoms and other psychosocial demands do get a higher level of input through case management or care coordination, whereas those progressing well towards their recovery still get the benefit of key workers support.

References

1. Department of Health. A national service framework for mental health. In Health Do editor. London Department of Health. 1999.
2. Dieterich M, Irving CB, Park B, et al. Intensive case management for severe mental illness. Cochrane Database Syst Rev. 2010. Contract No: CD007906.
3. Rosen A, Killaspy H, Harvey C. Specialisation and marginalisation: How the assertive community treatment debate affects individuals with complex mental health needs. The Psychiatrist. 2013; 37: 345–8.
4. Schwartz SR, Goldman HH, Churgin S. Case management for the chronic mentally ill: models and dimensions. Hosp Community Psychiatry. 1982; 33: 1006-9.
5. Kongstvedt PR. Essentials of managed health care. Burlington MA John & Bartlett Learning. 2013.
6. Haggerty JL, Reid RJ, Freeman GK, et al. Continuity of care: a multidisciplinary review. BMJ. 2003; 327: 1219.
7. Schottle D, Schimmelmann BG, Karow A, et al. Effectiveness of integrated care including therapeutic assertive community treatment in severe schizophrenia spectrum and bipolar I disorders: the 24-month follow-up ACCESS II study. J Clin Psychiatry. 2018; 75(12): 1371-9.
8. Baker F, Weiss RS. The Nature of Case Manager Support. Psychiatr Serv. 2006; 35(9): 925-8.
9. Thompson KS, Griffith EEH, Leaf PJ. A Historical Review of the Madison Model of Community Care. Psychiatr Serv. 2006; 41(6): 625-34.
10. Olfson M. Assertive Community Treatment: An Evaluation of the Experimental Evidence. Psychiatr Serv. 1990; 41(6): 634-41.