A model for the integration of alcohol and other drugs, community mental health and primary health care services

Presentation to FaHCSIA

July 2010

Introduction

1. The rationale for collaborative, needs based planning rather than competitive tendering for service development

2. The AMSANT AOD/mental health service model as part of community controlled primary health care

3. A case study of the service model at the Central Australian Aboriginal Congress

1

The rationale for collaborative needs based planning rather than competitive tendering for service development

Service Integration and economies of scale not fragmentation

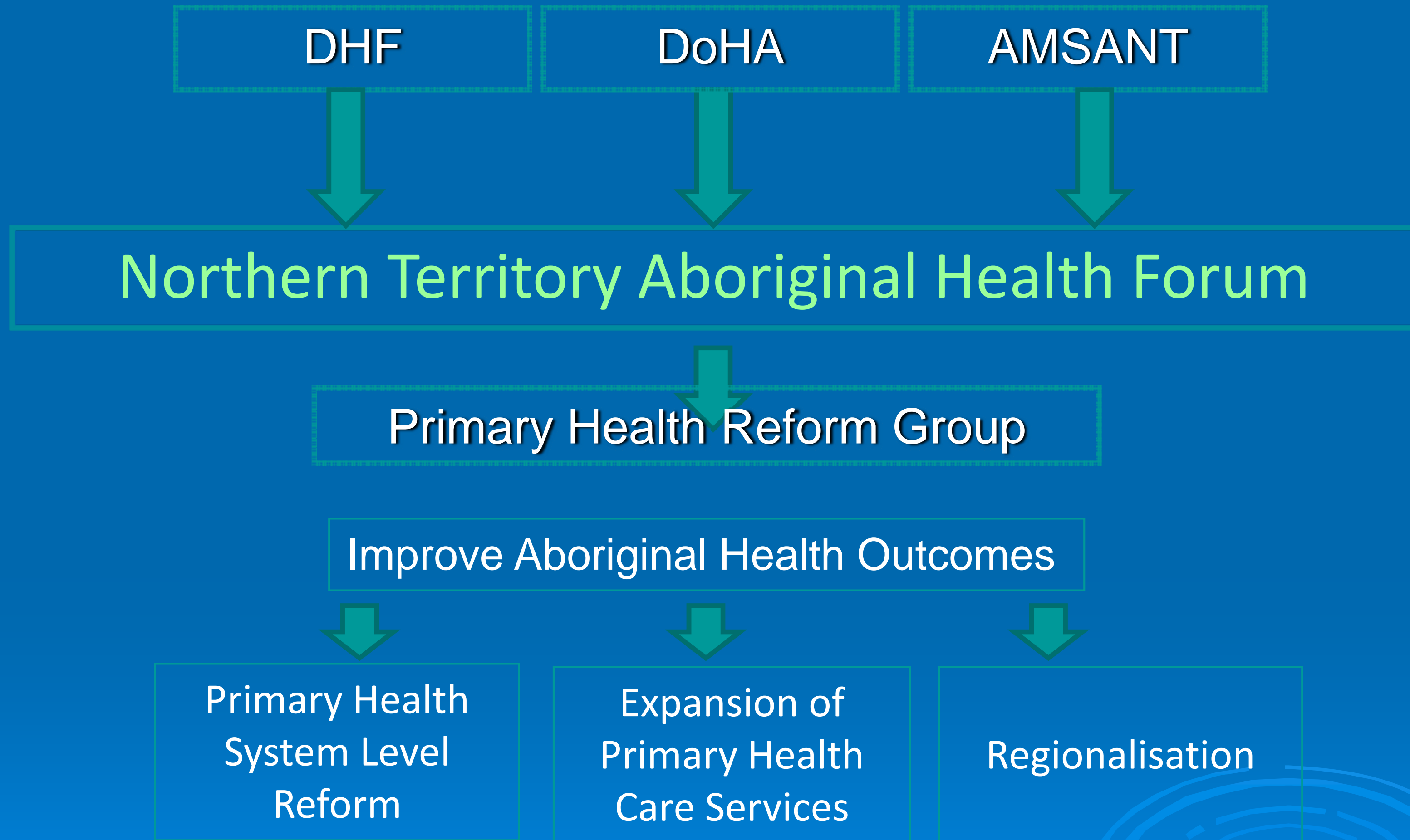
- The NTAHF agreed that it did not want the primary health care system made increasingly complex by the introduction of multiple new providers.

- The addition of non Aboriginal community controlled private providers leads to fragmentation of service delivery and makes it harder to achieve our goal of an integrated primary health care system, potentially resulting in poorer outcomes.

- It would also reduce the economies of scale being created through the regionalisation process for single, large, multidisciplinary service providers

- Haggerty, J.L., et al., *Continuity of care: a multidisciplinary review.* British Medical Journal, 2003. 327(7425): p. 1219-21.

Joint needs based planning for a better health system



Regionalisation: scaling up to larger ACCHS

- Reduce PHCAP health zones from 21 to 12-15 AHSDA's
- Create greater economies of scale to deliver a broader range of more effective, multidisciplinary, core services which include AOD, mental health services and family support services
- Create greater capacity for essential corporate support services
- Promote formation of large ACCHS within each AHSDA

Needs based planning, not competitive tendering, is working

- Using this agreed approach, the NTAHF has overseen the development of the Northern Territory Aboriginal health system in a way that is now delivering results in terms of improved health outcomes for Aboriginal people

- [1] Thomas, D; Condon, J; Anderson, Ian; Li, Shu Q; Halpin, S; Cunningham, J and Guthridge, S L. Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator, *MJA* 2006; 185 (3): 145-149
- [2] Wilson, T., Condon, J., Barnes, T Northern Territory Indigenous Life Expectancy Improvements, 1967-2004, *ANZJPH* 2007, Vol 31, 184-8
- [3] Katherine West Coordinated Care Trial-Final Report, Local Evaluation Team, April 2000, Menzies School of Health Research, Darwin.(source: www.menzies.edu.au/pls/portal30/docs/FOLDER/PUBLICATIONS/PAPERS/KWCCT_FINALREPORT.PDF)

Aboriginal community controlled CPHC is the way to invest

- For any given level of investment AMSANT believes that there are greater returns in terms of access, quality and health gain with Aboriginal community-controlled PHC compared with other models of service delivery, in spite of the small costs incurred in developing governing committees or health boards

Leadership and responsibility improve health

- Aboriginal governing committees provide leadership and action from and by our communities to improve our health – they are the antithesis of the passive welfare culture.

- Aboriginal people, through our own health services, are taking greater control of our lives and our health. We do not need government or non community controlled private providers doing everything for us – with all their good intentions we do not need Mission Australia, Anglicare, Centacare or any other charitable organisation

Key public health literature on control and health gain

- Low self esteem and lack of control are significant public health issue, especially for marginalised populations: Marmot, M. 1998, 'Contribution of psychosocial factors to socioeconomic differences in health', *The Millbank Quarterly*, Vol. 76, No. 3, pp 403-448; Marmot, M., Status Syndrome. London: Bloomsbury, 2004

- Indigenous communities that have either achieved self-determination through formal self-government agreements, or have initiated some degree of control over services within their community experience fewer to no incidences of suicide. In fact, those communities that have achieved some degree of self-determination experience a reduction in suicides by 85%: M.J. Chandler and C. Lalonde, "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations," *Transcultural Psychiatry* 35, 2 (1998):191–219.

Salaried multidisciplinary teams with a focus on CQI and data

- The Aboriginal community controlled service model is a “not for profit” corporate model that enables the employment of salaried practitioners working to shared goals with the time and capacity to provide holistic care to high needs patients
- There is a major focus on PIRS, data collection and quality improvement with the development of core services and core indicators

2

The AMSANT AOD/mental health service model as part of community controlled primary health care

History of service model

- Service model first presented to the NTAHF in February 2006
- Agreement was sought for a single, evidence based service model
- Sought commitment to funds pooling of new COAG mental health and AOD funds
- Combined NT allocation of more than $30 million recurrent could have seen the model implemented across the NT
- Failure to agree has allowed the process of competitive tendering leading to non evidence based, fragmented multiple, private providers

Service model: a snapshot

- Social health teams within every PHC service in each Aboriginal Health Service Delivery Area throughout the NT
- Community development approach
- Access to evidence based therapies, case management, medications and social support
- Flexible approach at the local level

Dual diagnosis – a creation of the health system

- Patients often have both a mental illness and an alcohol and other drug problem
- The approach to treatment is similar and includes the same core services
- The fact that these patients have been "buck passed" between AOD services and mental health services is due to the separation rather than integration of these services – it is a creation of the health system

Evidence for the integration of PHC, AOD and mental health

1. The primary Health Care Access Program (1999), agreed core services across all of the NT - urban and remote (2003); Expanded Health Services Initiative (2008)
2. NTAHF Social and Emotional Well Being Strategic Plan and the NATSISEWBSF (2003)
3. Senate Inquiry into Mental Health (2006)
4. NTG review of alcohol and other drug services (HMA consulting, 2006).
5. Dennis Gray et al 2004, NDRI

The core SEWB PHC services (1)

1. Primary and secondary prevention programs such as the Positive Parenting Program (PPP), the Family Well Being Program, Parents Under Pressure and Targeted Family Support and community development approaches employing local Aboriginal leaders that strengthen the families ability to deal with SEWB issues.

2. Multidisciplinary care plans and mental health plans, involving the client and their family creating community based rehabilitation and treatment plans including the provision of social support in areas such as housing, education and employment

The core SEWB PHC services (2)

3. Structured therapy to individuals and families
   - No evidence base that generic counselling works
   - Very strong evidence base for structured therapy such as Cognitive Behaviour Therapy (CBT) and others that include goal setting, motivational interviewing and problem solving skills. This includes family therapy and multi systemic therapy
   - CBT is effective for a broad range of conditions such as Depression, Anxiety states, ATOD problems, gambling and more.
   - A common misconception about the use of CBT among Aboriginal clients is the view that Aboriginal people are incapable of expressing their thought (cognitive) processes in sufficient detail to enable cognitive therapy to be effective.
   - Narrative therapy, art therapy and others can also be provided in addition to CBT but every patient who would benefit from CBT needs to be able to access this in their community
   - Structured therapy is not available in most Aboriginal communities in the NT.

The core SEWB PHC services (3)

4. Screening and brief interventions
   - well patients over the age of 15 for alcohol, tobacco and other drug (ATOD) problems and mental illness. This can be achieved as part of the 715 health check. Providing **brief interventions** on all patients identified with a problem.

5. Assessment and referral
   - ATOD and mental illness as identified in the screen and referred for a more comprehensive assessment. Ideally this assessment should be performed by a skilled, community based counsellor working within the PHC team.

6. Withdrawal in the home and in supported accommodation
   - Clients only need to be seen once daily in their home or supported accommodation facility where these exist. Treatment could be commenced in the clinic and then referred to the mental health nurse.

The core SEWB PHC services (4)

7. Provision of pharmacotherapies
   - include buprenorphine for opiate withdrawal or nicotine patches for nicotine withdrawal or longer term maintenance and/or slow withdrawal (eg buprenorphine or methadone for opiate withdrawal) or Acamprosate or Naltrexone for the management of alcohol cravings after a withdrawal episode. These services need to be provided by the community based GP who normally works as part of the PHC team. It is not acceptable that such services should only be available in specialist alcohol and other drug programs
   - Multiple medications for mental illness

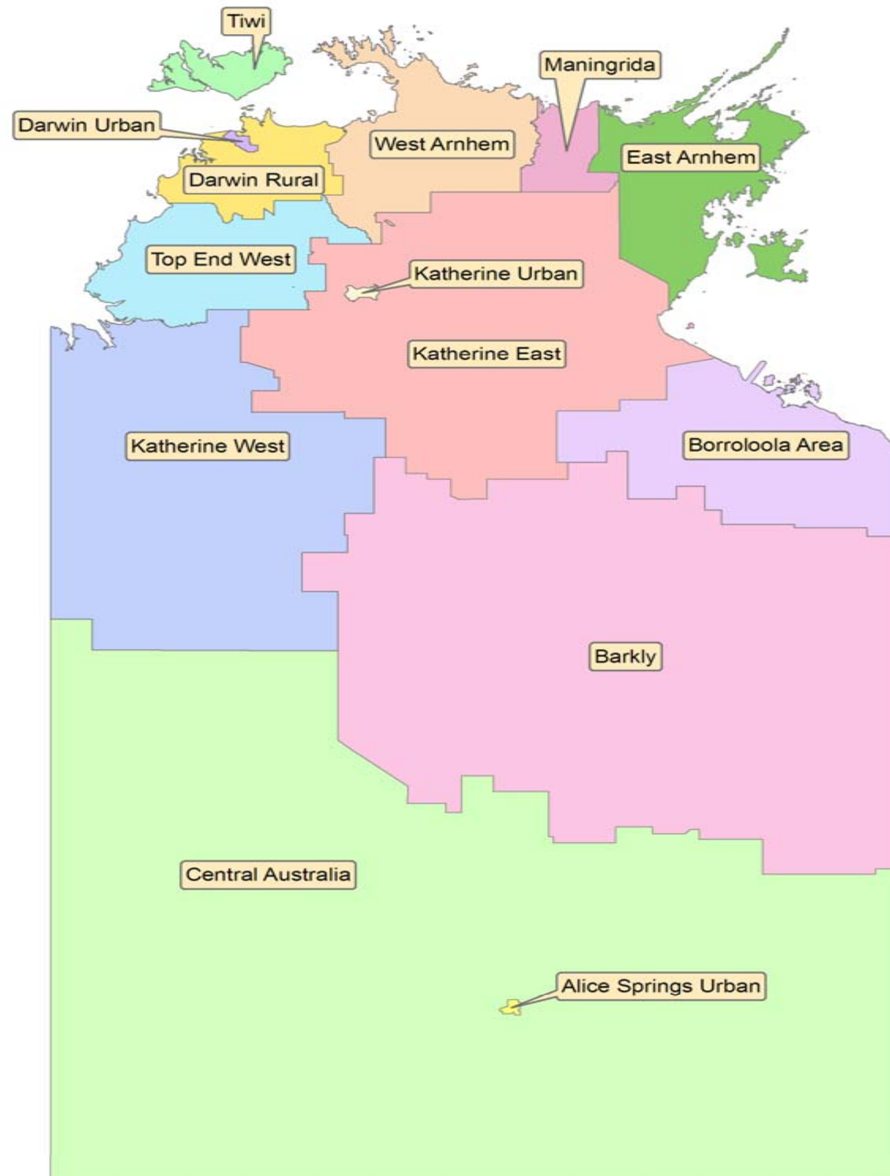
Non PHC alcohol and other drug and mental health services

1. Residential rehabilitation and treatment
2. Community based residential withdrawal and hospital withdrawal
3. Respite care and supported accommodation services
4. Acute psychiatric hospital services
5. Supported employment programs

Social Health teams in PHC services

- Service populations of 3000 or more people in each of about 16 Aboriginal Health Service Delivery Areas
- Single community controlled PHC provider
- The SEWB team for this population will be:
  - 2 psychologists
  - 4 Social workers (accredited with ASSW)
  - 4 Aboriginal mental health / AOD workers (RAHWs), or Aboriginal AOD workers or Mental Health Nurses
  - 8 Aboriginal Family Support Workers
- There will be one psychiatrist for every 8000 people working across AHSDAs

Northern Territory Health Sevice Delivery Areas.**



** The Northern Territory Health Service Delivery Areas are also the Northern Territory OATSIH Planning Regions that took effect from 1 July 2008.

Map produced by Program Management and Implementation Section, OATSIH 05 September 2008.

Where to begin?

- Full funding for a complete social health team and a SEWB program will take time in each AHSDA
- Recent AMSANT workshop agreed to begin with the combination of:
  - A therapist (psychologist or social worker accredited with the ASSW)
  - An Aboriginal worker who could be either an Aboriginal Family Support Worker, an Aboriginal AOD worker (cert 4) or an Aboriginal Mental Health Worker (RAHW)
- This initial team would provide assessment, therapy, social support and case management services to clients and families with a broad range of conditions. The team would also provide community development services

3

The service model in Central Australian Aboriginal Congress: a case study

Central Australian Aboriginal Congress (Congress)

- Congress is an Aboriginal community controlled health service in Alice Springs
- Service population of 6500 permanent clients
- Provides more than 70 000 episodes of care each year
- Multidisciplinary team of Managers, Public health practitioners, GPs, Nurses, Midwives, AHWs, Pharmacists, Psychologists, Social workers, Aboriginal Family Support Workers, allied health practitioners, drivers, receptionists, dentists and others
- Provides all of the core services in the AMSANT service model

Social and Emotional Well Being branch at Congress

- Began in 1999 with Regional Centre Funding
- Employs a social health team comprising of psychologists, social workers, Aboriginal Family Support Workers, Aboriginal AOD workers and Aboriginal case workers
- Services include structured therapies, family therapy, narrative therapy, case management, case coordination, social support,
- Integrate with the GPs for pharmacotherapies and care plans

SEWB functional areas

1. Community well being team with a focus on treating depression, anxiety and panic disorder, abnormal grief, major psychoses
2. An Alcohol treatment and rehabilitation program
3. A family support service providing case management and interventions for high needs families
4. A Youth Service

One Patient Information System

1. The complete information about a patient is in the one place with all practitioners caring for the patient aware of all of the patients issues
2. Common data collection systems are used across all functional areas of SEWB including common assessment tools such a the K10 and AUDIT as well as common mental health care planning templates
3. This can best occur by building the capacity of integrated AOD/Mental health services as part of CPHC

Clinical Record

Kuminljai XXXXX, THE MAN 41yrs Fictitious Patient Male (01/01/1969)

Summary | Progress Notes | Detail

Main Summary | Medication Summary | Social & Family History | Care Plan

Active Problem/Significant History

Date	Item Description
03/07/2010	smoking (tobacco) addiction "contemplation stage"
03/07/2010	alcohol dependence "10 SD per day"
16/03/2010	bronchial pneumonia
02/03/2010	chronic suppurative otitis media "L and R"
08/08/2009	coronary artery bypass graft "a;ldfkj;lafj"
19/06/2008	Hepatitis B Immune
19/02/2008	asthma
17/02/2006	diabetic coma "non compliant with meds"
09/11/2005	epilepsy
21/05/2001	type 2 diabetes
08/10/2000	hypertension
08/03/2000	coronary artery disease
04/08/1999	chronic alcohol abuse
19/05/1999	Self Harm - Thoughts/Ideas

Qualifier Summary

Qualifier	Value	Date
ACR (Alb/Creat Ratio)	3.4 mg/mmol	04/08/2009
Alcohol audit interview total	35 Score	03/07/2010
BMI	75.8 kg/m2	27/05/2010
BP - Systolic blood pressure	120 mm Hg	06/07/2010
BP - Diastolic blood pressure	60 mm Hg	06/07/2010
Blood glucose level - rand...	5.5 mmol/L	03/07/2010
Creatinine	80 umol/L	29/09/2005
GFR (ideal body weight)	89.2 mL/min	04/08/2009
HDL level	1.3 mmol/L	04/08/2009
Hb (Haemoglobin)	120 g/L	06/07/2010
HbA1c	13 %	23/03/2010
INR (International Normalis...	3 Ratio	06/07/2010
LDL level	2.1 mmol/L	04/08/2009
Oxygen Saturation	99 %	12/01/2010
Smoking status	Ex-smoker	06/07/2010
Total cholesterol level	4.2 mmol/L	04/08/2009
Triglyceride level	2 mmol/L	04/08/2009
Weight	112 kg	29/06/2010

Alerts and Other Information

At risk if appointments are missed

15/6/10 Is now a paraplegic and therefore the above comment does not apply RA

Adverse Reaction Summary

New Adverse Reaction | Nil Known

Type	Substance
Allergy	Penicillins
Allergy	Paracetamol
Allergy	Penicillins
Allergy	Chloroform
Allergy	grasses and pollens
Intolerance	lactose
Sensitivity	dog hair

To Do

Filter To Do List

Date	Item Description
23/02/2010	<Referred> low priority referral to dentist
15/03/2010	<Referred> referral "ent"
25/03/2010	<Recall> Diabetes Cycle of Care
21/04/2010	<Referred> referral "Dr jacob"
01/06/2010	<Recall> Care Plan For Completion "ready to sig...
08/06/2010	<Recall> Faeces Test
23/06/2010	<Recall> podiatry check-up
24/06/2010	<Recall> Pneumococcal 23 (Pneumovax)
24/06/2010	<Recall> follow up encounter "steve tomake co...
30/06/2010	<Recall> X-ray of the sacrococcygeal spine "rev...

Add Clinical Item - Kuminljai XXXXX, THE MAN 41yrs Fictitious Patient Male

SEWB Assessment Session

If you are starting an assessment ; do not forget to add 'Problem: Stolen Generations' as a condition.

(Administration - no client contact) 11/07/2010

Comment

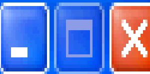
Display on Main Summary

Performed date 11/07/2010

SEWB Assessment Status (No previous values)

SEWB Assessment Outcome (No previous values)

Add Clinical Item - Kuminljai XXXXX, THE MAN 41yrs Fictitious Patient Male



SEWB Therapeutic Intervention

(Administration - no client contact) 11/07/2010

Comment

Display on Main Summary

Performed date: 11/07/2010

SEWB Intervention Type (No previous values)

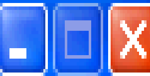
SEWB Sessions Completed: Number (No previous values)

SEWB Session Type (No previous values)

SEWB Therapeutic Intervention Outcome (No previous values)

Save | Cancel | Help

Add Clinical Item - Kuminljai XXXXX, THE MAN 41yrs Fictitious Patient Male



SEWB Therapeutic Intervention

(Administration - no client contact) 11/07/2010

Comment

Display on Main Summary

Performed date: 11/07/2010

SEWB Intervention Type (No previous values)

- Cognitive Behaviour Therapy
- Family Therapy
- Interpersonal Therapy
- Mindfulness-Based Therapy
- Motivational Interviewing
- Narrative Therapy
- Sand Play Therapy
- Supportive Psychotherapy
- Voice Dialogue Therapy

SEWB Sessions Completed (No previous values)

SEWB Session Type (No previous values)

SEWB Therapeutic Intervention Outcome (No previous values)

K10

For all questions, please tick the appropriate response.

In the past 4 weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.About how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
2. About how often did you feel nervous?	☐	☐	☐	☐	☐
3. About how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4. About how often did you feel hopeless?	☐	☐	☐	☐	☐
5. About how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6. About how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7. About how often did you feel depressed?	☐	☐	☐	☐	☐

Check up;alcohol;AUDIT

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during the past year".explained what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc.code answers in terms of "standard drinks".

(Administration - no client contact) 12/07/2010

Comment

Display on Main Summary

Performed date 12/07/2010

Ask question "How often do you have a drink containing alcohol?"

Alcohol audit interview Q1 (No previous values)

Ask question "How many drinks containing alcohol do you have on a typical day when you are drinking?"

Alcohol audit interview Q2 (No previous values)

Ask question "How often do you have six or more drinks on one occasion?"

Alcohol audit interview Q3 (No previous values)

Ask question "How often during the last year have you found that you were not able to stop drinking once you had started"?

Alcohol audit interview Q4 (No previous values)

Ask question "How often during the last year have you failed to do what was normally expected from you because of drinking?"

Alcohol audit interview Q5 (No previous values)

Engagement is not accidental

- ☑ Active response to referrals
- ☑ Outreach and opportunistic engagements in setting chosen by client
- ☑ A known third party ‘introduce’ practitioners to referrals
- ☑ Relational engagement within the kinship structure

Engagement…continuing!

- Collaboration with referring agencies
- Activation of referrals from residential and mandated referrers
- Learn, document and pass on local ‘Giving Away the Grog’ stories
- Community development in town camp and family groupings

How could this be funded?

1. The NT allocation from the COAG mental health reforms for rural and remote allied mental health, mental health nurses, Aboriginal mental health workers, PHAMs etc
2. COAG Alcohol and other drug services
3. Medicare eg mental health care plans, Fee for service items
4. Community Mental Health and AOD services: DHF funds pooling
5. Training funds
6. Need one off funding to build staff houses in the larger communities

COAG Mental Health initiatives: multiple "vertical" programs

- Expanding Suicide Prevention Programs
- Alerting the Community to Links between Illicit Drugs and Mental Illness
- Support for Day-to-Day living in the Community: Personal Helpers and Mentors (PHAMS)
- Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule
- New Funding for Mental Health Nurses
- Improved services for people with drug and alcohol problems and mental illness
- Mental Health Services in Rural and Remote Areas
- Improving the capacity of workers in Indigenous communities
- New early intervention services for parents, children and young people
- Additional education places, scholarships and clinical training in mental health

Conclusion

- The model will deliver efficient, accessible evidence based, quality care
- It is not too expensive – the money is in the system
- It applies equally across the NT – there is no specific "remote AOD" service model
- It requires a multidisciplinary team rather than a single "super" practitioner but the critical initial team is the skilled therapist and Aboriginal Family Support worker
- Aboriginal health services are capable of managing effective AOD/mental health services
- AMSANT has been lobbying for this evidence based approach since 2006 and in spite of this the large amount of new funding is being allocated within vertical programs in an uncoordinated manner often with inadequately skilled workers