**Improving throughput in a Youth Mental Health Service**

**Author 1**: Dominiek Coates, PhD, Researcher, Children and Young People’s Mental Health, Central Coast Local Health District, Gosford, Australia, Telephone: 61243287316, e-mail: Dominiek.Coates@health.nsw.gov.au

**Author 2**: Deborah Howe, RN, BA (Social Science), MPH, MHA, Service Manager, Children and Young People’s Mental Health, Central Coast Local Health District, Gosford, Australia, Telephone: 61243287316, e-mail: Deborah.Howe@health.nsw.gov.au

**Corresponding author:** Dominiek Coates

**Corresponding Author’s E-mail:** Dominiek.Coates@health.nsw.gov.au

**Abstract**

**Purpose**: The discrepancy between increasing demand and limited resources in public mental health is putting pressure on service managers to continuously review their practices and develop innovative care models that redress discrepancies. To ensure service models continue to meet stakeholder needs, Children and Young People’s Mental Health (CYPMH) managers conduct regular service model reviews. Accordingly, the CYPMH Youth Mental Health (YMH) model has evolved significantly over time in response to young people’s needs and service demand. This article outlines a recent YMH service review and subsequent changes to the service model.

**Design/Methodology/Approach**: Informed by a participatory action philosophy, feedback was sought from staff on the service model using a questionnaire, staff consultations through a working party and interviews. This feedback was used to redesign the model, which was then evaluated again.

Findings: Staff identified several challenges in the existing service model, recommending a few service improvement solutions. The key issues included exceedingly high caseloads, workplace tensions and fragmenting client journeys. We outline the primary solution to these key concerns, namely introducing brief intervention as the entry point to the service.

**Practical implications**: Brief intervention approaches provide a solution to high caseloads as the direct and focussed approach generally reduces the sessions people need. Brief intervention is an important addition to other treatment options and should be seen as a valid mental health care component.

# Keywords: Youth mental health service; Action research; Health service evaluation; Child and adolescent mental health service; Brief interventions; Demand management.

# Article Classification: Research

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# Introduction

Internationally, demand for healthcare services, including mental health services, is rising, putting pressure on service managers to reduce costs and demonstrate value. To cope with rising demand and cost, while continuing to deliver high quality care, healthcare staff must innovate and create service redesign initiatives (Ben-Tovim *et al.*, 2008; NSW Agency and Clinical Innovation, 2016). Increasingly, health service staff are engaging in continuous quality improvement and service evaluation practices to ensure and demonstrate quality and value (Bailie *et al.*, 2007; Chovil, 2009). Ongoing evaluation of service delivery helps determine service strengths and weaknesses to inform areas for further development. We outline a Youth Mental Health (YMH) service evaluation at the Children and Young People’s Mental Health (CYPMH), Central Coast Local Health District (CCLHD), New South Wales, Australia. Service Staff are committed to ongoing service evaluation and improvement, which includes a YMH service model going through numerous reform phases that have informed service innovation and change (Coates and Howe, 2015; Howe *et al.*, 2013; Howe *et al.*, 2015). The most recent YMH model review, conducted in late 2014 and early 2015, included service data analyses, interviews with clients and carers, staff consultations, and an in-depth literature review. Increasingly, feedback from key stakeholders, such as clients, carers and clinical staff, is recognised as central to service evaluation, development and delivery (Brunero *et al.*, 2009; Howard *et al.*, 2003). While consumer and carer feedback is outlined elsewhere (Coates, 2016), here we outline staff feedback on the service model, and describes the service improvement and redesign process this feedback informed.

The CYPMH YMH service provides a community based specialist tertiary service for young people aged 12-24 who experience moderate to severe mental health issues (excluding psychosis). Clients accepted into the service present with several issues, most commonly suicidal ideation, depression, anxiety, deliberate self-harm, aggression/anger, behavioural issues and family issues. Most clients fall between 13-17; 80.4% were under 18 years in 2012-2014. Young people aged 12-25 years are the most vulnerable to developing a mental illness and have the highest mental illness incidence and prevalence across the lifespan (Kessler *et al*., 2012; Kessler *et al.*, 2005; McGorry *et al.*, 2013; Milnes *et al.*, 2011). More than a quarter of Australians aged 16-24 experienced a mental disorder in the previous 12 months (Kessler *et al*., 2012; Kessler *et al.*, 2005).

The CYPMH YMH model has evolved significantly over time, having undergone numerous reforms in response to young people’s needs and service demands. To provide context to our evaluation, the most significant YMH reform phases are outlined. Prior to 2008, CYPMH predominantly operated as a Child and Adolescent Mental Health (CAMHS) and early psychosis (YPPI) service, which included three teams: (i) Consultation and Assessment Team (CAT); (ii) CAMHS (12-18); and (iii) YPPI (12-24). In 2007, following an increased recognition at a State and Federal level that many young people aged 18-24 were falling between CAMHS and Adult Mental Health Service gaps (Hickie *et al*., 2005; McGorry, 2007; McGorry *et al*., 2013), CYPMH secured funding to develop and evaluate a prototype YMH Service Model (Howe *et al*., 2013). In 2008, as a funding outcome, CYPMH staff expanded the care model to include young people 18-24 years with mental health problems (other than psychosis, as young people aged 18-24 with psychosis were already treated by the YPPI team). At this stage, the service provided intensive case management for young people aged 12-24.

This service change resulted in a significant increase in demand, which became increasingly difficult to meet. To assist demand management, a brief intervention (BI) team was introduced in 2011 to work alongside the case management team, called the YMH team. This change ensured that young people not requiring longer term case management, receive a brief service linked to appropriate non-government services. The BI team provided brief interventions (six to eight sessions) to clients deemed appropriate for this service at assessment, predominantly young people in situational crisis. Brief interventions tend to be solution focussed and are usually goal directed to address a specific problem. On completing this time limited service, clients were either discharged or transferred to the YMH team or the YPPI team. Clinicians from a previously larger YMH team staffed this new BI team. This service change assisted client throughput. Clients in situational crises coming into contact with the mental health service as the are no longer offered longer term case management. This allowed the YMH team to focus on clients with more complex issues. This was the YMH model during the review we discuss here.

**Research question and method**

The current service evaluation project was conducted within a continuous quality improvement framework, which conceptualises service evaluation as ongoing and integral for service delivery (Bailie *et al.,* 2007; Chovil, 2009). Informed by action research principles, the approach to service evaluation adopted by this service is cyclical and iterative; each data collection and analysis phase informs service development initiatives, which are then translated into practice and evaluated again (Baum *et al.*, 2006; Koshy *et al*, 2011; Schmittdiel *et al*, 2010). An action research design is concerned with generating solutions to practical problems by working collaboratively with all stakeholders, thereby enhancing the likelihood that research findings will lead to action and inform practice (Koshy *et al*., 2011). This approach is increasingly employed in health settings as it provides a framework for clinicians to research and reflect on their own practice in a systematic way (Koshy *et al*., 2011; Meyer, 2000).

As part of a larger YMH service evaluation to inform service development, feedback was sought from clinicians on the YMH service model using several methods. In close collaboration with clinicians, this feedback developed an enhanced model, which were then evaluated again. In accordance with action research principles, clinicians were actively engaged throughout the project, including developing, implementing and evaluating the new model. Active engaging staff in service evaluation projects is critical to ensure that service improvement strategies meet clinicians’ needs, are implemented and sustained (Chovil, 2009; Koshy *et al*., 2011). Staff are experts on service model strengths and weaknesses, and involving them in service design and redesign honours their perspectives and expertise (Chovil, 2009; Koshy *et al*., 2011).

The researcher was conceptualised as a facilitator who supported staff to identify service challenges, possible solutions and ways in which service improvement solutions could be embedded into practice. Informed by a participatory action philosophy, the researcher and participants were understood as partners in all research stages, who shared knowledge and power equitably (Schmittdiel *et al*., 2010). While the researcher used several methods to consult staff and documented the finding systematically, clinical staff were actively engaged in making sense of the findings and determining which actions should follow (Baum *et al*., 2006; Schmittdiel *et al*., 2010). This approach was used to encourage staff to own the quality improvement process and embed the service change recommendations into everyday practice (Chovil, 2009; Koshy *et al*., 2011). Several methods were used to bring out the staff voice and ensure that service improvement initiatives adequately address key stakeholder needs, namely, a staff questionnaire, staff consultations through a working party and one on one interviews.

*Approval*

Approval to conduct this evaluation was provided by the Northern Sydney Local Health District Human Research Ethics Committee and the Central Coast Local Health District Research Office.

### *Working party*

At the outset, all service staff were invited to an initial workshop chaired by the service manager (n=23). The workshop aimed to identify the YMH service model’s strengths and limitations from clinician and manager perspectives. Strengths and challenges with the current model were collated, as a starting point to this improvement process. All clinicians and managers were invited to participate in an ongoing working party to oversee this service evaluation and improvement project. This working party, chaired by the CYPMH researcher (first author), included 15 staff members: YMH managers and clinical staff. This working party met throughout the change process, until several service changes were embedded into practice and sustained.

### *Questionnaire*

All clinical staff and managers (n=23) were invited to complete a service satisfaction questionnaire at two points in the project: (a) at the start, to provide feedback on the existing model and put forward recommendations for model improvement; (b) after implementing a redesigned model based on feedback. Initially, this questionnaire was completed by 18 staff. Following the new model’s implementation, 19 clinicians completed the questionnaire again. The questionnaire captured staff perceptions and experiences of the initial and redesigned service model. The questionnaire posed questions about clinicians’ satisfaction with various service components (such as access to support, caseloads, meetings, client journey, etc.) asking participants to rate statements on a Likert scale from strongly agree to strongly disagree. Additionally, YMH staff were asked for qualitative feedback on why they were satisfied or dissatisfied. Participants were also asked to recommend service improvements. The qualitative data were analysed for key themes following guidelines by Braun and Charles (2006). At both project stages, findings were collated by the service researcher and presented to the working party for discussion and action.

### *One-on-one interviews with clinicians*

At the start, the researcher conducted one-on-one interviews with three current YMH clinicians and three clinicians who had moved from the YMH team to the BI team. Using a purposeful sampling approach (Babbie, 2004; Corbin and Strauss, 2014), the interview aim was to gain in-depth feedback on the service model from individuals who were identified as holding particular knowledge or expertise. Three clinicians who had moved from the YMH to BI team were approached; they were perceived as particularly knowledgeable about YMH and BI strengths and limitations. Interviews identified the challenges specific to the YMH team. To gain a balanced perspective, these data was supplemented with interviews with the three YHM clinicians who had demonstrated a sustained commitment. Three YMH clinicians were invited to participate in an interview, who were perceived as: (a) holding valuable historical insights about the service; and (b) able to identify team strengths. While it was anticipated that this evaluation would lead to redesign initiatives, care was taken not to ‘throw out the baby with the bathwater’ and maintain the existing model’s strengths in redesign initiatives. During the interviews, care was taken not to lead the participants by open-ended questioning and active listening skills. Questions included “what are your thoughts about the current model?”, “From your perspective, what’s working well and what could be improved?” and “Do you have any suggestions for service improvement?”. The interviews were analysed for key themes using Braun and Charles (2006) guidelines. Findings were collated by service researcher and presented to the working party for discussion and action.

# Findings

The project’s early stages identified the service challenges from the clinicians’ perspectives and possible solutions. From this, the service model was redesigned and the new model implemented and evaluated again.

## Service challenges

From clinical and managerial perspectives, we identified key challenges and a need for the service model to be reviewed and changed. Table I (questionnaire results) showed that out of 18 respondents only two were satisfied with the current model, 11 were dissatisfied and 5 were neither satisfied nor dissatisfied.

**Table I here**

There agreement on what key issues with the model were, regardless of the method used (working party consultation, questionnaire or individual interviews), or which team the participant worked with (BI, YMH or CAT). Both the qualitative and quantitative results identified the following issues as most significant: high caseloads in YMH, tension between YMH and BI team leading to insufficient communication and support, and fragmenting client journeys.

*Rising demand leading to unmanageable YMH team caseloads*

A key issue identified was rising referrals without increasing resources, and particularly the impact on their YMH team. Service data shows that referrals to the YMH service increased by approximately 100 per year over the last three years (830 July 2011 to June 2012, 977 July 2012 to June 2013 and 1040 in July 2013 to June 2014). Referrals meeting service criteria and accepted rose (from 78%, to 80.3%, to 84.3%). Service data are consistent with evidence mental illness in young people increased over time (Eckersley, 2011). While rising service demand is a challenge for both the BI and YMH team, this was in particular a key issue for the YMH team who worked with the most difficult and complex clients, and often had caseloads exceeding 20 per clinician. High and complex caseloads in this team led to staff burnout and high staff turnover:

Caseloads are not manageable based on staff to client ratio. It’s unsafe, and the client journey is constantly interrupted by trying to stop gap staff shortages or availability. This appears to have a great impact on staff job satisfaction and clients declining service or failing to engage with the service (questionnaire 1, participant 1).

Working in a time-poor manner means staff are rushed, produce less than best work, cannot plan sufficiently due to the need to continuously prioritise, are not able to take proper self-care, often skip lunch or eat on the run, need to cancel client contact in order to attend to administrative tasks and are limited in being able to attend meetings and training (questionnaire 1, participant 2).

*Tension between teams*

The BI team in 2011 assisted with client throughput and helped manage demand, but it added an additional strain on the YMH team, which now only worked with the most complex and high risk clients with more established mental health problems. The BI team provided a service to clients in situational crisis and who are likely to benefit from a brief service. During 2013-2014, treatment duration for clients referred to the BI team averaged 44 days, while the duration for clients referred to the YMH team averaged 139 days. When clinicians were asked to comment on the strengths and challenges, the discrepancy or tension between how the two teams were perceived by clinical staff was highlighted. The BI team was perceived as overwhelmingly positive, with one identified limitation or challenge. Clinicians described the BI service as rewarding, goal directed, achievable and manageable. It’s only identified limitation was the possible client journey fragmentation as some BI clients may need to be transferred to the YMH team if they require a longer term intervention. In conflict to this, when asked to reflect on YMH team challenges and strengths, clinicians primarily identified challenges, in particular around client and family complexity, limited access to senior staff (as more senior staff worked in the BI team). Clinicians commented that only working with those highly complex clients is exhausting and that they would like to experience visibly seeing clients improve more common to the BI team:

I feel that the BI model works well in that individuals do not carry stress and risks associated with more complex clients and have lots of support in place … It appears that staff have more time for planning, reflection and professional development. I am not satisfied with the model for the YMH team in particular as it can feel as though there are inequities between the teams and there is a large amount of pressure and stress associated with managing large caseloads, complex clients and families (questionnaire 1, participant 3).

*Fragmenting client journey*

The fragmenting client journey was also identified as a limitation as clients may see multiple clinicians (in CAT and BI) before referral to the YMH clinician for longer term case management. While most clients are referred directly from CAT to the appropriate team (BI, YMH or YPPI), some clients are transferred between teams, primarily from BI to YMH (n=59, 5.7%) as explained by one participant:

Clients report they meet many clinicians and have to repeat the story over again and this leads to disengagement … Rapport begins in assessment and having a clinician who can follow through with treatment would shorten the time clients spend with the service (questionnaire 1, participant 4).

## Service redesign: parallel teams with brief intervention as the entry point

Forty-six possible solutions were put forward by the participants (through the questionnaire , interviews and group consultations), which were brought to the working party for discussion and action. Some solutions were not feasible because they were not cost neutral, such as “to recruit more staff”. Given the mental health service’s current financial climate, these suggestions were removed from the options list. Other proposed service improvement strategies included changes to recruitment and orientation practices, using technology, better outcome measures to inform service delivery, earlier discharge planning and a service redesign initiative. While all these solutions hold merit and are being addressed to varying degrees, we outline the most significant solution or service change resulting from this evaluation, namely the redesign initiative.

Considering the proposed solutions, the service researcher returned to the literature for guidance on how the various recommendations could be implemented and which strategies other mental health services have used to manage demand. The literature review was presented to the working party and a decision was made to merge the YMH and BI team into two YMH teams that provide the same service. Consequently, the YMH and BI team were combined and then divided across two teams (YMH Red and YMH Blue), which now offer the same service. Rather than having one team offering brief care packages and another team offering longer term case management for highly complex clients, all clinicians now have a case-mix with clients on either a brief intervention or a longer term care package. The service was divided into two teams with two team leaders to ensure clinicians continued to have sufficient access to leadership support.

This service change addresses some key limitations of the previous model by more evenly distributing the workload and complexity/mental health acuity across both teams. This change removed the tension between the teams, as both now provide the same service. Furthermore, this change positively affects the client journey as clients no longer transfer from one team (and clinician) to another. Clients are now allocated to a clinician and a care package, and can move from one care package to another if required, while remaining with the same team and the same clinician. With a few exceptions, clients enter the service on a brief intervention care package and only if clinically indicated are they moved onto longer term care. The brief care packages are called brief intervention (BI), minimum management plan (MMP), and transitional care. The MMP care package is used for all clients with suicidal/self-harm behaviour; transitional care is used for all clients who have recently been admitted to a mental health inpatient facility; and the BI package is the entry package into the service for all other clients (excluding early psychosis) and includes up to six sessions.

Young people can be transferred from one package to another, dependent on their clinical presentation at any time. While brief intervention may be appropriate as the entry point to a service, if clinically indicated a client subgroup is transferred to a longer care package, the case management package. In particular, those young people who are the most at risk and hardest to engage are likely to require a longer term outreach case management service. The case management package includes weekly or fortnightly appointments (dependent on acuity) and is focused on therapeutic intervention and risk management. This stepped care model, with the least intensive intervention that is appropriate for a person (i.e., BI) provided first, and the opportunity to step up or down as required, is increasingly highlighted in the literature as most appropriate, in particular in the public sector (Bloom, 1981; Gee *et al*., 2015). Evidence supports the efficacy of brief interventions, including child and adolescent services (Campbell, 2012; Gee *et al*., 2015; Perkins, 2006; Perkins and Scarlett, 2008; Talmon, 2012; Young *et al.,* 2012). As it is almost impossible to predict who will need or benefit from longer term care at the initial contact, it is appropriate for brief intervention to be the entry point to a service (Gee *et al*., 2015; Young *et al*., 2012). Many therapy improvement occur in the initial one to four sessions, with therapeutic gains slowing in subsequent sessions (Gee *et al*., 2015; Talmon, 2012).

Brief interventions challenges many traditional therapy assumptions, which tend to locate responsibility for change in the therapist’s expertise and conceptualises change as a long term and difficult process (Campbell, 2012). In contrast, BI considers that change is part of life and that clients only need clinical support for brief periods, to be able to utilise their own resources to solve their problems (Campbell, 2012; Gee *et al*., 2015). This approach fits well within a more recovery and resilience based treatment philosophy (Gee *et al*., 2015), to which direction this service is committed. Brief therapy approaches empower clients to use or fine-tune existing skills and resources to better manage their problems (Gee *et al*., 2015; Olesen *et al*., 2010). While BI may be an effective treatment for many clients, some may need longer term interventions and these clients are identified and transferred into a longer term care. While there is some evidence that suggests that a brief intervention approach is effective when working with hard-to-engage patients (Young *et al*., 2012) or young people with complex presentations (Perkins, 2006), there is evidence indicating that BI is most appropriate for moderate problems (Allison *et al*., 2000; Hampson *et al*., 1999). Those young people who are the most at risk and hardest to engage are likely to require a longer term outreach case management service (Schley *et al*., 2011).

## Redesign implementation and evaluation

Approximately eight months following implementation, staff were invited to complete the service satisfaction questionnaire again (Table I). Satisfaction with the service improved significantly across all domains. While initially only two participants were satisfied with the model, now 18 are satisfied. Only one was neither satisfied nor unsatisfied and none dissatisfied. In particular, qualitative component shows that staff report the following positive outcomes: more balanced caseload mix with different client acuity and complexity levels; enhanced opportunity for skills development for all clinicians as they work with several clients with different needs (situational crisis and more established mental health problems); enhanced continuity, with clients no longer transferred between clinicians; and better communication and collaboration between the two teams who now operate in the same way. Comments such as “New model appears to have had very positive effect on team morale and the team is now really rather special” (questionnaire 2, participant 1); “I believe it has been a fantastic model change, I enjoy being at work much more, and am glad the changes were made. Thank you” (questionnaire 2, participant 2) and “No need to change the model further, it’s good now as is” (questionnaire y 2, participant 3) were common. These findings are supported by service data. Approximately eight months following implementation, the service researcher analysed data again to sense the change’s impact. Data show that while total clients referred to the service remained the same, clinicians have lower overall caseloadsowingto the overall reduction in stay, and a more balanced client acuity in their caseloads. As BI is the service entry point, clients are no longer inadvertently given a longer service than required. In 2014, average length stay for all clients (YMH and BI) was 130 days; following the model change, stay reduced to 92 days. Service data as well as questionnaire findings were discussed at the YMH working party for possible action. Given the high satisfaction with the new model, a decision was made that no further changes need to be made to the current model.

# Conclusion

The discrepancy between increasing demand and limited resources in public mental health is putting pressure on service staff to continuously review their practices and develop innovative care models that redress this discrepancy (Gee *et al*., 2015; Kazdin and Blase, 2011). While the evidence base for brief intervention is strong, increasingly mental health services use BI out of necessity as to cope with the excessive service demand (Miller, 2008; Perkins, 2006). Brief intervention approaches provide a solution to high caseloads as BI’s direct and focussed approach generally reduces the sessions people need (Gee *et al*., 2015; Young *et al*., 2012). Brief intervention is an important addition to other treatment options and should be seen as a valid mental health care component (Gee *et al*., 2015). While BI is not the solution for everyone and some people do need longer term treatment, by not holding on to those who can draw on existing resources in their recovery, time is freed to work with those clients who need longer term care (Young *et al*., 2012). Our evaluation highlights ongoing service assessment to provide high quality evidence-based services that meet all stakeholder needs, including clinicians. Staff wellbeing is a critical issue when developing high quality mental health services (Farhenkopf *et al*., 2008; Montgomery *et al*., 2011; Walsh and Walsh, 2001; Williams *et al*., 2007). While staff burnout in mental health care can, in part, be attributed to client groups, especially when working with highly complex clients, service design plays a critical role in protecting staff against burnout (Coates and Howe, 2014; Coates and Howe, 2015). In particular, caseload size and complexity in assertive outreach models can affect staff wellbeing and burnout (Billings *et al*., 2003). The current service redesign project recognises the clinician experience when designing and developing sustainable service models. Regular service reviews ensure that teams remain reflective and innovative in their practice and identify and respond to issues as they arise. Ongoing service evaluations ensure that service delivery meets clients, carers and staff needs, and should be standard practice for all mental health services.

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**Table I:** Survey results

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Model 1 Review (n=18)** | | | **Model 2 R view (n=19)** | | |
| **Item** | **Strongly agree or agree** | **Neither agree not disagree** | **Strongly disagree or disagree** | **Strongly agree or agree** | **Neither agree not disagree** | **Strongly disagree or disagree** |
| Overall, I am satisfied with the YMH clinical model | 2 | 5 | 11 | 18 | 1 | 0 |
| YMH caseloads are manageable | 2 | 8 | 8 | 17 | 1 | 1 |
| Staff have adequate access to peer/senior support | 4 | 6 | 8 | 19 | 0 | 0 |
| Staff have adequate access to peer/senior support | 4 | 7 | 7 | 19 | 0 | 0 |
| There is efficient structure for discharge planning | 6 | 5 | 7 | 18 | 1 | 0 |
| There is efficient structure to the clinical review meetings | 10 | 5 | 3 | 18 | 0 | 1 |
| Staff have adequate access to medical staff | 11 | 3 | 4 | 17 | 0 | 2 |
| Staff have adequate access to their team leader | 12 | 1 | 5 | 19 | 0 | 0 |
| There is sufficient structure to the morning meetings | 14 | 4 | 0 | 18 | 1 | 0 |