

Adult Community Mental Health Services

(Metropolitan Regions)

Integrated Model of Care

June 2009



Government
of South Australia

SA Health

This page intentionally blank

TABLE OF CONTENTS

SA HEALTH STATEMENT OF ACKNOWLEDGEMENT.....	4
INTRODUCTION.....	5
BACKGROUND.....	7
SECTION 1: SERVICE PARAMETERS.....	8
1.1 Primary Mental Health Care and Early Intervention.....	8
1.2 Service Delivery Parameters	8
1.3 Service Components	9
1.4 Service Integration.....	10
1.5 Working in Partnership.....	10
1.6 Integration Principles.....	11
SECTION 2 – MODEL OF CARE COMPONENTS	12
2.1 Model of Care Parameters	12
2.2 Principles of Consumer Engagement	12
2.3 Core Components	13
2.4 Aboriginal Mental Health.....	14
2.5 Continuum of Care	15
WORKFORCE.....	17
SAFETY AND QUALITY.....	18
FACILITIES.....	19
SECTION 3 – OPERATIONAL DETAILS.....	20
3.1 Service Components.....	20
3.2 Key Service Components	25
3.3 Key Therapeutic Interventions	26
3.4 Workforce Organisation	26
3.5 Key Worker Functions.....	27
3.6 Consumer Allocation and Review Process.....	27
3.7 NGO Responsibilities at Sector Level.....	28
ENDNOTES	31
APPENDIX 1: EXAMPLE OF A ZONING BOARD MODEL.....	33
APPENDIX 2: RECOVERY.....	34
APPENDIX 3: LITERATURE REVIEW	37
APPENDIX 4: BIBLIOGRAPHY	39
APPENDIX 5: SECTOR MAP	41

SA HEALTH STATEMENT OF ACKNOWLEDGEMENT

For Aboriginal people, health is a matter of determining all aspects of their life, including control of their physical environment, of dignity, of community self esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

Health is both a fundamental human right and an important worldwide social goal and is defined as a state of complete physical, mental and social wellbeing.

The South Australian Government is committed to improving the status of Aboriginal people in South Australia through addressing all aspects of life, including health status.

Aboriginal People and the Health System

Aboriginal people have continuing rights and responsibilities as custodians of their land associated with traditional ownership and as members of kinship groups and families.

Aboriginal people experience a range of health challenges attributable to the on-going impact of colonisation and to many socio-economic factors.

The historical and contemporary context and conditions, within which Aboriginal South Australians live, including the loss of country, have made it difficult to attain and sustain good health and wellbeing. Widespread social disadvantage and poor physical, spiritual and emotional health impact on many Aboriginal lives. Full or partial exclusion from employment opportunities, poor housing and education, exposure to unacceptable environmental conditions and over-representation in the justice system place Aboriginal South Australians at much higher risk of social stress and health disadvantage than non-Aboriginal South Australians. The continuing poor and unmet health needs of Aboriginal people further compounds the stress experienced, adding to the burden of disease across the community.

Given this context, SA Health will support individual, family and community health and wellbeing initiatives that address the complex interaction of social, cultural, economic, and physical environments in which Aboriginal people live.

SA Health will continue to develop and implement strategies to provide health services and models of health care that address the patterns and burden of disease experienced by Aboriginal people as a whole and by particular population groups such as men, women, the elderly, children and young people.

Statement of Commitment

SA Health is responsible for the provision of a range of health services in primary health and acute care settings. The specific needs of Aboriginal people will be met through a comprehensive primary health care approach that addresses physical, mental and social health and wellbeing. The particular needs of Aboriginal people will be addressed in all areas of SA Health's responsibility.

SA Health is committed to improving health outcomes for all Aboriginal people in South Australia so that the differences in their health status and the rest of the South Australian population are eliminated.

INTRODUCTION

This Adult Community Model of Care describes the service level parameters that direct the provision of community mental health services to adults aged 18-65 years across the two Adelaide metropolitan health regions - Central Northern Adelaide Health Service (CNAHS) and Southern Area Health Service (SAHS). The Country Mental Health Services Model of Care document describes service provision outside the metropolitan area.

As consumers access and are supported through their journey towards recovery, each service component that crosses the lifespan and forms the complete stepped pathway of care is described in an associated suite of documents which together inform all Mental Health Care Service delivery across South Australia.

This document should be read in conjunction with the over-arching Policy document *South Australian Mental Health and Wellbeing Policy* (the *Policy*), which provides the Strategic Context, Background and Vision, Objectives and Principles which have guided the reform and delivery of all mental health services in this State.

South Australia's Mental Health and Wellbeing Policy builds on the strategic reforms and recommendations outlined in *Stepping Up: A Social Inclusion Plan for Mental Health Reform 2007-2012* and the *Review of Community Mental Health Services in South Australia (2008)*. The *Policy* aligns with the key strategic objective of the SA Health Strategic Plan to reform mental health care in South Australia and Target 2.7 of South Australia's Strategic Plan to improve psychological wellbeing in South Australia. The policy is also consistent with the directions of the National Mental Health Strategy, including the National Mental Health Policy 2009 – 2014 and the National Mental Health Plan 2009 – 2014.

The *Policy* describes in detail each of the elements that are common across all areas of Mental Health Care service provision, with clear and identified priorities: Rights and Responsibilities; Health Promotion, Prevention and Early Intervention; Access and Integration of Services; Statewide specialist mental health services and interventions for high risk groups; Partnerships and Inter-Agency Co-operation; Workforce Development and Planning for the Future; Safety and Quality; and Knowledge Management, Information and Research.

All information pertaining to Care Planning is addressed in the *SA Mental Health Care Plan Information Booklet* and *Mental Health Care Plans* which are developed by consumers, carers and clinicians will ensure that the consumer is actively engaged in the process of their care and treatment.

Likewise, all information pertaining to Assessment is addressed in the *Combined Regions Mental Health Assessment* and associated *Business Rules* document, produced by the SA Mental Health Unit, which will become the Standard Mental Health Assessment and Risk Assessment tool for South Australia. The tool has been designed to support clinicians from within all adult and older persons' mental health services to conduct, record and communicate assessments in a manner which supports best outcomes for clients, carers and clinical teams.

This Adult Community Model of Care is presented in three sections:

Section 1 establishes the social care context for adult community mental health care within the wider sphere of primary mental health care and early intervention. Service Organisation, Service Delivery, Integration between mental health care service elements and the Continuum of Care across sectors are described in this Section.

Section 2 describes in more detail the Core Components of the Model of Care which are the cornerstones upon which community-based mental health care is delivered, across all six geographic sectors (four in CNAHS and two in SAHS).

This Section also contains the fully integrated Core Elements of Aboriginal Mental Health Model of Care as recommended in the *Aboriginal Mental Health Consultation Report (draft, 2008)* to ensure that services to Indigenous people are addressed in a manner and using methods that are respectful of their cultural needs.

Operational details describing how the services described in this document will be implemented are located in Section 3.

Section 3 provides the Operational Details of service delivery which are common across all community mental health services, grouped into **Consumer issues** of access, assessment, care planning, care co-ordination and **Workforce issues** of case allocation, key worker roles, case load management, emergency assessment and intervention; walk-ins; referrals and triage, and case closure.

Whilst recognising that groups of mental disorders, conditions or illnesses have previously been used to structure service response, the clinical delivery of services for specific conditions and treatment protocols are deemed to fall within the realm of clinical management protocols rather than prescriptive service management issues.

The intent of the reform process within community mental health care is to provide seamless service delivery based on consumers needs supported by a well-trained mental health workforce across multiple disciplines, regardless of specific diagnosis.

Information contained in this document will also inform the functional design process for Community Mental Health Centres.

Appendices to this document include an example of a Zoning Board model of case allocation, a Literature Review and Bibliography, and a discussion of the philosophy of Recovery which underpins this document.

BACKGROUND

This document is the result of an extensive collaborative consultation and workshop process with all stakeholders including consumers and carers, government agencies and non-government service providers, and reflects ongoing work to implement recommendations emanating from the two key reform reports described in the *SA Mental Health & Wellbeing Policy* document, ie: the Social Inclusion Board's *Stepping Up Report* (2007) and the *Community Mental Health Services Review* (also known as the *Honeyman Report*, 2008). The Adult Community Model of Care reflects both a recognition and acceptance of the need for reform by all stakeholders and a commitment to its implementation.

Community Mental Health Care is provided by primary health care services, statewide specialist area mental health services and a number of non-government organisations (NGOs) who are funded by SA Health and other agencies to provide defined services. Other non-government service providers also provide various levels of care, and the interface with such providers is recognised as a critical aspect of continuity of care for consumers who engage with both private and public sector services.

The SA mental health reform agenda has led to the creation of six (6) geographic sectors in the Adelaide metropolitan area. A map of new sectors together with total and adult population data is attached at Appendix 5 to facilitate and improve consumer access and deliver services closer to those in need of care. The catchment areas and preferred suburban locations for each Community Mental Health Centre (CMHC) were announced by the Chief Executive SA Health on 13 October 2008. Boundaries are consistent with Regional Health Services and conform to the new whole of Government organisational boundaries.

Each Sector will operate a CMHC as part of an integrated care system, linked to other care facilities across the community to enable and enhance the stepping up and down of care as required by consumers on their journey towards recovery.

Adults aged 18 to 65 years will be the primary focus for Community Mental Health Centres. Staff will work collaboratively with Child and Adolescent Mental Health Services (CAMHS) for consumers aged 16 to 24 years in recognition of their specialist needs and the importance of a seamless transition with the adult sector should it be required. An Early Psychosis Intervention Service model will link with both the CAMHS and this Model of Care.

Close co-ordination of services across age groups is required as people transition out of one service into another relevant to their requirements, and flexibility will be maintained in terms of eligibility for service on the basis of age. Community Mental Health workers will continue to work with consumers presently receiving services who are over 65 years, in partnership and collaboration with Mental Health Services for Older People.

It is recognised that consumers may require considerable support to shift to this new paradigm as the service system to which they may have become accustomed changes. Sound communication and transition processes will be in place with consumers and carers across all Sectors to ensure that everyone involved is kept advised and aware of the movement towards implementation of a significantly enhanced service delivery system.

SECTION 1: SERVICE PARAMETERS

This Section outlines the social care context of adult community mental health care within the wider context of primary mental health care and early intervention, describes the Service Delivery parameters, various components that together comprise Community Mental Health, their organisation and their delivery at Community level.

1.1 Primary Mental Health Care and Early Intervention

The *SA Mental Health and Wellbeing Policy* document states that:

“The primary health care sector will play an important role in improving access to mental health care and the provision of mental health care services. As the first level of contact with the health care system for most people, primary health care services can provide improved opportunities for prevention and detection of mental disorders, as well as treatment and follow-up, including the treatment of co-morbid physical conditions.” (p 8)

Community Mental Health Services will work collaboratively with regional Primary Care services – increasingly through GP Plus Centres. Primary Care services provide programs for people whose problems increase their vulnerability to mental illness. Where joint programs or services exist across sectors, liaison and referral pathways will be developed to ensure consistency across all Sectors. As GP Plus Centres develop, a range of structured therapy groups, targeted at people with the most common disorders - anxiety and depression – will be provided collaboratively through all Community Mental Health Services.

Community Mental Health teams will, through their strong consumer focus, act in all of the above cases as the catalyst for increasing the uptake of these services, and as the early warning monitor for indications of the need for more training, development and/or resources in any of them.

People experiencing a first episode of psychosis will often present to their GP in the first instance. This is a crucial point in providing an effective early intervention service.

1.2 Service Delivery Parameters

1. Community Mental Health Centres (CMHC) in each sector will provide the primary location for delivery of integrated services. Some sectors may require secondary service delivery locations to improve their ability to deliver services.
2. Each CMHC will provide public clinical mental health services and psychosocial rehabilitation care funded through NGOs to people with moderate to severe mental health problems, and associated psychiatric disability.
3. Each CMHC will be self-sufficient in capacity to provide the majority of core services to its catchment population. For services that cannot be configured on a “per sector” basis, a hub and spoke service model will apply which effectively engages local sector staff in the coordination of service delivery to best meet consumers’ needs.
4. Some specialised services will be provided by partnerships between Sectors or coordinated through state-wide networks. The creation of sectors will not affect a consumer’s right to access specialist services provided by or located in another Sector.

5. Each CHMC will operate under revised common management structures which reflect the new integrated service delivery model described herein.
6. Sector Managers and Community Mental Health Teams will oversee the consumer journey, case management, care-co-ordination, care planning, and interaction with a range of other service providers to ensure that continuity of care is achieved across the spectrum of consumer needs.
7. Core Elements of the Aboriginal Model of Care, described in the *Aboriginal Mental Health Consultation Report (2009)* will be an integral component of all mental health care service delivery statewide.

1.3 Service Components

Under this Model of Care, two core components of community mental health care delivery are recognised: “Acute” and “Community” – through which care services are delivered from Community Mental Health Centres.

From the consumers’ perspective these components will be seamless and essentially invisible from wherever they enter the service delivery system.

Acute Care

When in crisis, consumers need timely access to safe, high quality acute treatment services in the least restrictive environment and they and their carers need confidence that information already provided will be shared by all professionals involved to prevent unnecessary delays and the repetition of known, recorded information.

In response to this, Community Mental Health Services will provide a stepped range of services, with intensity tailored to meet consumers’ needs. Intensive emergency response and assessment and home treatment will be available where appropriate, as an alternative to intermediate or hospital in-patient care. The community emergency response service will operate over seven days, with intensive home visiting for a brief duration. The consumer’s key worker will be responsible for coordinating such care and ensuring all information is kept up to date.

Assertive Community Treatment is a subset of ‘Acute’ services which sits between “Acute” and “Community”, with primary responsibility for delivering intensive outreach support over extended hours using intensive teams-based programs to engage with at-risk consumers. Team members will also provide integrated care planning and co-ordination with all service providers and will follow clients through intermediate care and hospital-based care until they return to “normalised” services under the auspices of their local community mental health care teams.

Community-based services delivered from Community Mental Health Centres form the core central component of mental health services, and cover the full spectrum of care, for both planned routine assessments and unplanned or walk-in assessments. The scope of services delivered through CMHCs extends across structured and specialised treatment programs, Rehabilitation & Recovery programs, Psychosocial services etc. To ensure no gaps in service provision, community team members will provide follow-up to acute home treatment, intermediate or hospital care, and provide the pivotal link to all other services required by consumers.

1.4 Service Integration

The *SA Mental Health & Wellbeing Policy* – “Access & Integration” section describes the 5-steps of care provision from least to most intensive care services, including supported accommodation, community rehabilitation, intermediate care, acute care and secure care.

“As the centre of the stepped system of care, community mental health centres will ...provide a number of vital clinical and non-clinical roles including assisting people to live independently, crisis intervention, case management, mental health care and support services, assistance with accommodation, employment and advocacy and respite for carers.” (p8)

This Model of Care has integrated the Core Elements of the Aboriginal Mental Health Model of Care as described in the *Aboriginal Mental Health Consultation Report (draft, 2009)* to ensure that services to Indigenous people are addressed in a manner and method respectful of their cultural needs.

Safety and Quality is a core component required for all models of care and has likewise been integrated into this Adult community Model of Care to provide a mechanism for monitoring outcomes, and reviewing performance against National Standards, with the aim of achieving the highest possible level of mental health care for South Australians.

1.5 Working in Partnership

In order to achieve and deliver integrated community-based care, a very high degree of partnership processes will drive service delivery at all levels. Community Mental Health teams will deliver services in partnership with consumers and their carers, as well as with other relevant health and community agencies from both government and non-government sectors.

Sector Managers and Community Mental Health teams will establish positive working partnerships with consumers and their carers, and with service providers at all levels, within and across their own sector, with other Community Mental Health sectors, within their own and other regions. Partnerships will be focused on the consumer at the centre of care, understanding that people with mental illness must be enabled to participate in and lead their own recovery, in conjunction with their carers.

Strong working partnerships will be developed across the spectrum of government and non-government agencies to develop working relationships that enhance the best outcomes for consumers, eg: Aboriginal health agencies and advocacy groups, accommodation agencies, recognising that successful treatment is dependent upon the consumer being in stable, appropriate housing; Drug & Alcohol Services SA for treatment of consumers with substance-use co-morbidity issues; Justice and Correctional services system for young adult offenders with mental health disorders.

Community Mental Health Sector Managers and teams will work with other agencies to define role clarity, and will work towards achieving and maintaining positive working relationships which operate at a systemic level.

1.6 Integration Principles

The principal integrating mechanisms which exist within each and across all Community Mental Health Sectors have been grouped according to Consumer, Aboriginal and Management issues:

Consumer-driven integration issues:

- The integration of service components will be such that there is no perceptible delay by the consumer in engaging with staff within the community mental health team, regardless of the point of entry to care.
- As specified in the *Policy* document, consumers with multiple and complex needs are consistently recognised as a “high priority”, quickly identified and referred to appropriate teams for their care needs.
- All referrals across all levels of service providers will be responded to in a timely fashion.
- Transfer of case management between sectors or between service providers will be a seamless process to ensure that no gaps occur in service continuity.

Management integration issues:

- Standard documentation will exist across all mental health service providers
- Agreed common procedures and protocols will exist for triage, assessment, risk assessment, care planning, discharge/transfer of care
- Case note information will be shared as appropriate; when possible a single medical record will be used.
- Standardised Care Plans will be developed in a structured, recovery-focused format (in accordance with the Mental Health Care Plan Information Booklet and associated care plans);
- A common mental health information system will exist which meets the needs of all users and is accessible across the system (right information, right place, right time).
- Adherence to national and state mental health standards will occur, eg: national standard for clinical review, communication with general practitioners, discharge planning from inpatient to community.
- Clear, common and consistent business rules exist between all service providers, for example those pertaining to the completion of data input by both clinicians and administrative staff to the CBIS system, and for the transfer and handover of client information.
- Whilst community-based residential units (CRCs and SRFs) will retain their own staff, policies and procedures, within Sector management arrangements, they will be closely linked to community-based professional staff and will utilise common business rules.
- Clear service-wide consistent communication protocols will enable staff members to communicate directly with their colleagues in other Sectors
- Standardised computer systems will enable immediate transfer of key documents (including case notes, Care Plans and relevant reports) between Sectors

SECTION 2 – MODEL OF CARE COMPONENTS

This section describes “how” the Model of Care directs the provision of community mental health services to adults aged 18-64 years.

2.1 Model of Care Parameters

The Model of Care parameters within which integrated adult community mental health teams operate are:

- A consumer-driven perspective of service delivery
- Recognition of the importance of recovery and for pathways of care that are consistent with individuals’ needs
- Enhanced service responsiveness
- A highly developed professional workforce
- Utilisation of evidence-based best practice principles
- Consistent standards of care based on National Standards

2.2 Principles of Consumer Engagement

Principles guiding effective consumer engagement require the development and maintenance of a strong therapeutic relationship. The authors of ‘Framework for Health’ (2007)¹⁴ suggest the following:

- Building a relationship with consumers and carers must be based on empathy, genuineness and non-judgmental attitudes.
- Respecting the consumer and carer experience and communicating this back to the consumer and carer.
- Using the consumer frame of reference through recovery-focused discussion and interventions.
- Letting go of previously held perceptions and judgements.
- Being present to the consumer’s immediate and evolving experience.

Consumer engagement also requires collaboration with consumers around goal setting and developing self management skills. Again, the ‘Framework for Health’ (2007)¹⁴ authors suggest the following:

- Exploring information with consumers and carers to assist with informed decision-making.
- Recognising the consumer’s capabilities and motivations in treatment and those of the clinician.
- Avoid ‘pushing’ or coercing the consumer to change. Anticipate that the consumer is capable of participation.
- Assist the consumer to determine what they need and want and support the process of how to get there.
- Be transparent regarding responsibility, accountability and expectations for participation in the intervention.
- Engagement progresses with the fostering of ‘hope’ and ‘growth’ through the implementation of the Recovery Framework (2008)¹⁵.
- Focus on developing a sense of hope, growth and self determination.
- The feeling of hopelessness is often a response to complex presenting issues.

Reflective practice requires clinicians to acknowledge their reactions to consumers and seek supervision, support and consultation.

2.3 Core Components

Consistency of practice and service delivery will be achieved by adhering to the following fundamental elements which apply across mental health care service delivery regardless of where or how a consumer accesses community mental health services.

Consumer Driven

Services will be driven by the individual consumer's particular needs at any given time, their physical and mental health and wellbeing and their journey towards recovery.

Consumers with High and Complex Needs

As described in the *Policy* document, this cohort is one of a range of consumers with a high priority for service response, which will be addressed by identification of both clinical and other service needs which may be met by a range of agencies, and through strong collaborative partnerships with other service providers.

Key Worker

Every consumer will have an allocated a key worker ie a "known person", who will provide a single point of contact for consumers and will maintain constant awareness of the current status of care, regardless of where the consumer is placed on the care pathway.

Duty Work

To ensure prompt service response, each Sector will have a staff duty work arrangement for management of unplanned presentations and requests for service during normal hours of service.

Walk-in

To facilitate walk-in requests for service, each sector will have administrative and clinical response processes in place to manage walk-in requests for service. This will need to be allied with the Duty Work process for delivering care. The existence of physical capacity in terms of available workspace is critical to achieving this core aspect of service delivery.

Collaborative Partnerships

As described in Section 1, Mental Health clinicians and workers will work collaboratively with workers from other parts of the health system, other government agencies and non-government organisations to achieve the best outcomes for and in the best interest of consumers and carers.

Community mental health workers may be required to act in a leadership role in initiating and sustaining such relationships.

Safety, Quality and Outcomes

As described in the *Policy* document, National Mental Health Policies and Standards and robust monitoring processes will be established at sector management level to ensure evidence-based best practice is delivered to consumers and to demonstrate improved client health outcomes as part of a continuous quality improvement cycle.

These safety and quality priorities will include the development by each CHMC of a *Mental Health Safety and Quality Framework* for the implementation, evaluation and continuous quality improvement within community mental health services in line with national and state policy directions. The *Framework* will delineate the aims of high quality care in terms of safety, effectiveness, and patient-centred, timely, and efficient care domains, and include the agreed national and state performance indicators for community mental health services.

Priorities will exist that ensure consistent, safe and evidence-based practice in mental health service delivery under the *SA Mental Health and Wellbeing Policy* including each of the following:

- consumer and community participation
- governance and accountability
- monitoring and evaluation
- physical health and wellbeing
- the safe use of medicines
- reduction of adverse events
- safe use of transport for consumers.

2.4 Aboriginal Mental Health

The following core elements of Aboriginal Mental Health care will ensure that services to Indigenous people are addressed in a manner and using methods that are respectful of their cultural needs.

1. Getting in through the door: Engaging in care

Opportunities for improving engagement can be fostered and enhanced at several levels, particularly those related to working closely with Aboriginal Health Workers, and providing culturally responsive and assertive services at first presentation. One example is ensuring that referrals for Aboriginal people are followed up within 24 hours and seen face-face within 48 hours.

2. Ongoing engagement: Remaining in care

Aboriginal people have clearly articulated they wish to have choice about involvement of Aboriginal service supports or mainstream services, which may change during care. Offering choice for Aboriginal worker and service involvement throughout the provision of care and treatment is a key factor in Aboriginal people remaining in care. The involvement of Aboriginal workers, advocates or family spokespeople, going with the immediate identified need and providing practical support regarding social and family difficulties are also important considerations.

3. Geographical boundaries: Transfer of care

Communities have acknowledged that the itinerant nature of many Aboriginal people creates significant issues for continuity of medical treatment and mental health care. However, for many people this may also have a cultural healing component in re-connecting them back to important family and community members, culture and country, particularly following an inpatient stay away from their community. Managing itinerancy requires flexible boundaries, assertive follow-up and significant communication and goodwill between services.

4. Going to the people: Community care

Attending hospital and community mental health facilities often creates excessive anxiety, agitation and emotional distress for many people, so they do not access services or choose to remain engaged in care. Provide environments or services where people feel comfortable such as in the home or local community venues.

5. Working with families: Holistic care

Including family in care is central. A core value of Aboriginal people is the relationships they have with others. This central understanding of the importance of relationships and family has a complex system of responsibility and avoidance, even within more westernised cultures and a broader understanding is required of what this responsibility means in the care and protection of relatives and extended family.

6. **Ngangkari's and cultural healing: Traditional care**

Connecting people with family, community, culture and country promotes a sense of self and community value and provides opportunities for strengthening the family and the community. For this to be effective, families and communities require practical support and the provision of resources, without which interventions may be or become counter-productive. Valuing, respecting and utilising cultural and traditional ways of healing in partnership with mainstream and other therapies was supported.

7. **The Patient Journey: Consistent, Planned care**

Specifically, improving the collaborative partnerships, communication and working relationship between Aboriginal Health services and workers, mainstream mental health services and General Practice and Primary Health Care through consistent policy, procedures and targeted programs is essential. Clarifying roles and responsibilities for case management of the illness and emotional wellbeing, management of lifestyle issues and re-integration back into families and communities is required.

2.5 Continuum of Care

The Community Mental Health Care Service's recovery-oriented philosophy informs and supports the specific service responses described below.

1. Access to Services

As stated in the *Policy* document, the SA Mental Health service philosophy is to provide access to the best possible mental health care to all consumers, and to deliver proactive, timely intervention and continuing care with the aim of preventing or reducing the likelihood of crises arising.

Easily identifiable, multiple entry points along the care pathway and transparent accessibility will provide consumers with responsive, appropriate care (right time, right place, right care).

2. Assessment

All information pertaining to Assessment is addressed in the *Combined Regions Mental Health Assessment* and the associated *Business Rules*, produced by the SA Mental Health Unit, which becomes the Standard Mental Health Assessment and Risk Assessment tool for South Australia. The tool has been designed to support clinicians in all adult and older persons' mental health services to conduct, record and communicate assessments in a manner which supports best outcomes for clients, carers and clinical teams.

3. Consumer Physical Health and Wellbeing

Physical health is a vital component of general wellbeing, and screening must occur at the point of entry for all consumers coming into the mental health system. Regular physical health screening must occur throughout the consumer's time with mental health services and appropriate follow up must be offered. Community Mental Health Centres will identify and respond to general health risks which are more prevalent in people being treated for mental illness, eg diabetes, obesity, tobacco use. This will require strong partnerships with General Practitioners and other community-based primary health services

Consumers and carers must receive both education about lifestyle, and links to appropriate groups or services and physical health monitoring, focusing on areas of known high risk to people with a mental illness. Interventions should focus on assisting the consumer to make choices regarding their own physical health and wellbeing. Where necessary, close partnerships should exist with the consumer's GP and other workers (e.g. practice based nursing and allied health professionals) involved in supporting the consumer's physical health.

4. Care Planning

As a matter of standard Mental Health Unit Policy, each consumer and their carer will be directly involved in their own care planning, in accordance with the *SA Mental Health Care Plan Information Booklet* and associated Care Plan documents.

The Care Plan remains with and travels with the consumer and the carer. It will be easily available and will apply across all components of the Mental Health Care service system. The Care Plan will be regularly updated with the consumer and carer to reflect the consumer's strengths, needs and goals. The Care Plan is to be used as a statement of current interventions.

Expert information about treatment choices will be provided to consumers and carers in a clear and understandable manner.

WORKFORCE

The *SA Mental Health & Wellbeing Policy (draft)* states that a sustainable mental health care system depends on the knowledge, skills and commitment of those responsible for delivering services, and the importance of acknowledging the link between the overall wellbeing and skills of the mental health care workforce and the wellbeing of consumers of mental health care services.

Three key priorities are identified as:

- Recognition and support of mental health workers
- Training and development of staff
- Recruitment and retention of staff

Further, the *Policy* document acknowledges the importance of mental health literacy and skills of workforces in non-health sectors who engage with people with mental health problems, and the need to enhance their skills to more effectively provide services to consumers with mental health needs.

This Adult Community Mental Health Model of Care recognises and endorses consumers' fundamental needs for a culturally-competent, respectful and accessible workforce which will support them to learn more about themselves and focus on them being the expert in their care.

Workforce policies and protocols must preserve this capacity, to enable its growth and to sustain a level of service that is capable of meeting consumer and carer expectations. The following factors are important considerations in achieving this:

- Community Mental Health teams will contain a mix of professional disciplines, skills and qualifications, which, along with clinical leadership and teamwork, are key elements which assist in determining successful consumer outcomes.
- Community Mental Health teams will maintain a balance of Psychiatry, Nursing, Social Work, Psychology and Occupational Therapy members.
- Peer and carer specialist workers will be included as an integral part of the multi-disciplinary team.
- Aboriginal and Indigenous consumers' needs for culturally-competent and respectful assessment and treatment will be met by an appropriately trained workforce across all aspects of service delivery as a core component of this and all SA Mental Health Models of Care, as described above.
- Aboriginal mental health workers in all service settings will receive be respected for their personal, cultural and professional knowledge, experience and expertise in the delivery of mental health services to their people.

SAFETY AND QUALITY

The focus of all safety and quality strategies in health care delivery is to enhance consumer health and wellbeing. It is important to acknowledge that mental health service delivery, while it shares much in common with health care delivery generally, can also present quite different challenges from most other areas of health care. This is primarily because of the responsibilities related to administering legislative powers for mandatory treatment. It is critical that a balance is achieved between individual rights to dignity, respect and privacy and the need to protect the personal safety of consumers, staff and others, including families, other consumers, visitors, and the public. A basic underpinning principle is that mandatory treatment is to be used only when less restrictive options are not available, and should not be perceived or used by anyone as a punishment or coercion. The existence of powers of mandatory treatment requires mental health services and professionals to actively identify, prevent and reduce iatrogenic harm.

Safety and quality in mental health care depends on a commitment to consistently achieve the highest possible standards of care, adhere to current evidence-based practice and increase the likelihood of desired outcomes for consumers. Services will make every effort to identify, avoid or reduce actual or potential harm from mental health care delivery. Consumers and carers will be informed and involved in the planning and delivery of safety and quality programs and service improvement strategies in all adult community mental health care settings.

The application of sound governance and accountability requirements, mechanisms for service monitoring based on measurable standards, good information management practices and a motivated, well-trained workforce is vital. Good governance structures will involve transparent decision-making and clear accountability for the delivery of the best possible standards of care and continuous improvement of services. Services will be monitored and evaluated across the continuum of care to ensure the best possible health care is provided to people with mental health problems or a mental illness.

Treatment of co-morbid physical health problems and the safe use of medications for people with mental illness and mental health problems will be a key component of South Australia's quality and safety agenda. People with serious mental health illness experience far poorer physical health than the general population and the use of medications to treat psychosis can have significant adverse effects on an individual's physical health. Mental health services and professionals must be able to actively identify, prevent and reduce harm to physical health associated with treatment for mental illness.

These safety and quality priorities will include the development of a *Mental Health Safety and Quality Framework* for the implementation, evaluation and continuous quality improvement within community mental health services in line with national and state policy directions. The *Framework* will delineate the aims of high quality care in terms of safety, effectiveness, and patient-centred, timely, and efficient care domains, and include the agreed national and state performance indicators for community mental health services.

FACILITIES

Community Mental Health Centres

Six (6) Community Mental Health Centres will be established in the metropolitan area.

Other Facility Considerations

Due to their geography and physical size, some Sectors may require additional staff bases or visiting locations will be required to facilitate consumer access to services. 'Satellite' locations will be considered where these issues are apparent on a Sector by Sector basis.

As part of an integrated system of care, the provision of Community Rehabilitation Centres (CRC's), Intermediate Care Centres and other supported residential and activity centre developments are fundamental. (Refer to the relevant Models of care for a description of service provision and links to this Model of Care.) Consideration of future requirements for providing a range of supported and independent living services must consider both horizontal and vertical integration of service system elements in order to meet consumer expectations for continuity as part of a linked system of care.

SECTION 3 – OPERATIONAL DETAILS

3.1 Service Components

Community Mental Health Centres will be the central point of coordination of service delivery - not just of those services provided out of these locations but a linked service system that engages the inputs of psychiatrists, GP's, government and non-government organisations, inpatient services, and a range of other community supports intended to sustain the person within their environment.

In all cases and across all service components, CMH Teams will:

- Maintain a philosophy of recovery from first contact
- Ensure that the core principles of recovery and citizenship inform an extended role both for consumer and carer participation and community organisation partnerships in service planning and delivery.
- Recognise each individual's abilities and strengths, not only their difficulties and disabilities
- Consider major issues identified by the consumer as requiring resolution to be considered as a priority for action
- Collaborate with the consumer, their carer and key stakeholders, to develop and maintain a current consumer's care plan and a wellness recovery action plan, founded on evidence-based best practice
- Establish and maintain collaborative partnerships with primary health care providers to ensure that physical health needs are routinely reviewed

It is recognised that continuity of services to consumers is a primary consideration, and since not all partner organisations will be located within the local CMHC catchment area, those consumers with multiple needs who access agencies and services in other areas will continue to be supported by their local Community Mental Health Care Service.

In such cases, Community Mental Health Centres will establish close liaison with relevant local services and groups, and will provide a comprehensive range of information about other relevant local agencies and services and assist with referral and seamless transfer where appropriate.

Community Mental Health Centres will provide a wide range of services to meet consumers' needs at various stages of their journey, which will include:

1. Acute - Emergency Response for Assessment and Treatment
2. Early Intensive Programs
3. Rehabilitation and Recovery
4. Specialised Services
 - Perinatal disorders
 - Eating disorders
 - Anxiety disorders
 - Affective disorders (including Bipolar and major depressive disorders)
 - Severe personality disorders
 - Schizophrenia and related disorders
 - Forensic MH Service links – separate Model of Care

- Early Psychosis programs – separate Model of care
- Living & Psychosocial Interventions – see other Models of Care
- Employment options - refer also to the IPRSS and NGO Models of Care

“Hospital in the Home” services are currently provided as an extension of Mental Health Inpatient Services, and are fully described in that Model of Care.

As part of the service-wide continuum of care, CMHCs will provide a keystone link to all other aspects of mental health care to ensure that no service gaps exist for consumers.

1. Acute Services

- Emergency response for assessment and treatment, by phone or in person, at home or in the community
- A consistent, structured referral and assessment process will exist across all aspects of mental health care service delivery sectors, statewide
- Duty Worker availability within normal hours and over extended hours
- Consultation and liaison with general hospital services including Emergency Departments, especially with respect to discharge and follow up in the community
- Culturally-competent and respectful assessment, intervention and follow up with Aboriginal members of the community and with members of various CALD communities
- Key Worker follow up contact with consumers admitted to intermediate care centres, community recovery centres and in-patient hospital care
- Key Worker follow up after discharge from acute general health service interventions, and mental health inpatient stepdown care

Home Treatment and Hospital Avoidance

Acute home based treatment can be a successful alternative to hospital care (Hoult, 1983)¹³. The target group are consumers with acute mental illness, newly presenting or with an exacerbation of a known illness, without major general medical disorder, living in a safe and stable environment with a carer network, capacity for self care and safety at home.

Home treatment will be planned and coordinated alongside the consumer and their family by the key worker. The key worker will enlist help to provide the intensity of service required.

Interventions will include the full range of clinical assessment tools and therapeutic treatments, in collaboration with carers, consumer and the GP. The mental health team may visit several times a day during the acute phase. The response would normally include peer support involvement.

Home based treatment may also be used after discharge from brief hospital admission. Peer support programs will be implemented that focus on daily living practicalities such as ensuring food is purchased, electricity connected, personal hygiene etc.

Consumer Needs:

- Timely access to safe, high quality emergency response and assessment when in crisis and treatment in the least restrictive environment
- Confidence that information already provided through a care plan will be shared by all professionals involved.

Service Responses:

- Emergency response, assessment and treatment at home where appropriate, at times as an alternative to intermediate or hospital care.
- The service will operate over seven days, with intensive home visiting for a brief duration
- Links to Intermediate care services for short term residential treatment and support
- Links to Intensive assessment and treatment which cannot be safely provided in less restrictive settings will be conducted in an acute psychiatric hospital care.
- Following an emergency service response, plans for further treatment will be coordinated jointly by the psychiatrist and the consumer's designated community key worker in conjunction with the consumer, their carer and the consumer's and carer's current care plan.
- The consumer's key worker is responsible for information sharing with the consumer and carer, other workers engaged in providing services (as agreed with the consumer) and works to implement the care plan.
- The key worker will take a lead role in the coordination of all aspects of care.
- The lead role may include direct involvement in assessment, care planning and treatment whether the setting be acute care in the home, intermediate care facility or in the hospital

2. Early Intensive Community Programs

CMHCs will provide intensive recovery-focused treatment and care for consumers early in the course of serious illness.

In some Sectors, where the professional capacity exists, Early Psychosis services for younger people may be provided in collaboration CAMHS services, and may also provide these services to consumers from other Sectors. In doing so, firm adherence to standard assessment, intervention, documentation and transfer of care processes is required to ensure consistency and continuity of service and records.

Consumer Needs:

- Prompt access into services which can recognise their needs, establish a diagnosis and provide treatment

Service Responses:

- Routine exploration and discussion must occur with the consumer and their carer of how multiple factors impact on the consumer's life, with referral to the agency or services required to meet that need, as agreed to with the consumer and their carer.
- CMH Teams will maintain engagement with consumers and carers, at times intensively, when the consumer has difficulties over several domains – for example, illness symptoms, substance use, unstable accommodation, poverty, problems with self care or social skills.
- Intensive rehabilitation programs will provide community based support and day programs to assist consumers in their journey towards recovery. (See below)

3. Clinical Psychosocial Rehabilitation Services

Clinical psychosocial rehabilitation programs deliver clinically based interventions which incorporate both group and individual interventions delivered by multidisciplinary teams of clinical and non-clinical staff. Programs will facilitate and support consumer involvement in planning, implementing and evaluating programs.

Sector Managers will ensure that all staff providing such interventions receive the appropriate professional clinical supervision and support.

The role of clinical psychosocial rehabilitation programs is to provide comprehensive assessment delivered by skilled clinicians in conjunction with the consumer to identify functional capacity and therapeutic intervention goals. The assessment informs individual goal setting and the development of individual and group therapeutic interventions based on:

- Individual consumer needs as identified through evidence based outcome measures such as BASIS32, K10+, HoNOS, LSP, surveys and consultation meetings.
- Assessment tools such as the Model of Human Occupation (MHO), the Assessment of Motor and Process Skills (AMPS) or other standardised assessment tools for function.

Services may include a range of training programs including living skills, self-management, vocational rehabilitation, therapeutic activities, community development projects, joint agency partnerships, consumer empowerment and consultation.

Consumer Needs:

- Access to an appropriate range of professional and non-clinical programs.
- Access to a variety of opportunities through government and non-government organisations and other agencies.

Service Responses:

- CMH Teams will provide mental health specific expert advice to consumers, their carers, psychosocial rehabilitation and support providers, housing management providers and other key stakeholders.
- CMH Teams will provide access to a range of clinical assessments and treatment options, including but not limited to occupational therapy living skills assessment, psychological assessments and treatment, risk assessment and diagnostic assessment.

4. Living and Psychosocial Interventions

Accommodation Options:

- Intensive support with residential component (CRC) Refer to CRC Model of Care.
- Less intensive support. (more info please)
- Assisted access to independent living and support services.
- The identification of consumers' housing and accommodation needs is an essential part of the initial and ongoing assessment process, as there is strong evidence to indicate that stability in housing is an essential component impacting directly on a consumer's recovery.

Employment Options:

- Satisfying work or activity is essential to a person's recovery. Integrated service delivery is best practice for enabling mental health consumer employment outcomes. Community Mental Health Teams will include NGO employment specialists, working in partnership; care and employment plans will be integrated.
- Consumers, carers, psychiatrists, key workers, psychosocial rehabilitation workers and employment specialists will collaborate to ensure education, training and employment and/or activity goals are addressed
- Progress towards consumer employment/activity goals is never deferred until the consumer is "more recovered". When the expressed consumer goal is mainstream work or study, the Community Mental Health Team will provide the necessary referrals and support at the earliest opportunity.
- When the consumer goal is another activity (eg physical or creative), the CMH Team will arrange for access to relevant specialists, support or special interest groups, and will retain involvement with the consumer and carer to ensure satisfactory progress is being achieved.
- The employment specialist will discuss employment history, aspirations and skills with the consumer and carer. A plan for reaching the goals will be developed collaboratively and job-search commenced rapidly. Support will be provided for as long as it is needed, within and/or outside the workplace, according to consumer, carer, trainer and employer preference.
- Employment goals will be discussed by consumers, carers and mental health teams routinely in three-monthly clinical reviews and at other times as required. Treatment and support will be adjusted to best support consumer employment goals.

5. Specialised Services

Consumer Needs:

- Local response (assessment and/or treatment and rehabilitation) for mental health problems with differing or complex presentations
- A standardised, quality response and referral pathway for people with high prevalence disorders such as anxiety and depression.

Service Responses:

- All CMHC Sectors will ensure access to the full range of specialist services, whether provided locally or with another Sector or agency.
- Partnership with Drug and Alcohol Services South Australia (DASSA). Due to the increasing prevalence and treatment issues associated with co-existing drug or alcohol dependency, a close partnership between each Community Mental Health Team and the nearest DASSA team is essential.

3.2 Key Service Components

1. Assessment

The primary documents governing Assessment are the *Combined Regions Mental Health Assessment Tool* and *Business Rules* that support that document, issued by SA Mental Health for use by all clinicians statewide to ensure consistency across all points of service delivery.

To fully inform the needs the consumer identifies, the assessment processes used by clinicians will:

- Focus on the person and the issues that impact on their functioning within their environment – not solely the issues relevant to the nature of the illness.
- Focus on the consumers demonstrated resilience and capacity to meet their needs over time.
- Include psychiatric, psychosocial and social functioning domains, including an analysis of risk to self and others, both current and historical.
- Employ a holistic approach with housing, financial and occupational status included from a strengths perspective.
- Include an examination and information on general physical health
- Identify any co-morbidity problems in terms of disability and poly-substance misuse.

2. Care Coordination

Care coordination is a critical element in the provision of a transparent seamless service for the consumer and their family. This process will be provided by the Key Worker, to ensure clear oversight, effective management and integration of services supporting consumers.

Excellent partnerships and clear communication protocols and processes are required for effective care coordination.

3. Therapy

Therapy is defined as an evidence-based intervention provided by trained and supervised professional staff. Sector Managers will provide oversight and will co-ordinate this to ensure fidelity across Sectors and to ensure equity to consumers and their families.

Clinical Protocols will exist to ensure that the right type of therapy is given at the right time and evaluation mechanisms will exist that assess therapy outcomes.

4. Transfer of Care

Standardised protocols will exist across all mental health care service providers to ensure seamless transfer of care occurs for consumers across all aspects of service delivery. All aspects of the transfer of care process must fully involve the consumer, carer and significant others at each stage along the pathway of care.

Uniform protocols will exist to ensure clear, consistent interpretation and application of the transfer process.

3.3 Key Therapeutic Interventions

The range of treatments below will be available as a minimum in each Community Mental Health Centre. It is not intended to be an exhaustive list.

A clinical review process must be established before introducing new or innovative treatments, based on evidence of likely benefit, and ongoing evaluation.

All staff will be expected to engage in clinical supervision, both of and by their peers, to ensure the delivery of best practice therapies.

Psychological Therapies (may be delivered by various clinicians):

- Collaborative Therapy
- Cognitive Behavioural Therapy (CBT)
- Behavioural Therapy (BT)
- Motivational Therapy
- Dialectical Behaviour Therapy (DBT)
- Family interventions

Physical Therapies:

- Medication
- Electro Convulsive Treatment (ECT)

Living and Psychosocial Interventions:

- Supported accommodation options
- Intensive support
- Intermediate care
- Assisted access to independent living options
- Structured rehabilitation
- Vocational and occupational options
- Activities intended to enhance social inclusion

3.4 Workforce Organisation

The following Operational Details of work organisation describe processes and organisational arrangements across all Community Mental Health Centres. Variation may occur between Sectors offering different services.

- Sector Managers will provide overall management of Community Mental Health Teams in their Sector
- Team Managers will be senior clinicians who may or may not also carry a caseload
- Individual workers will be allocated work within the context of overall workload management for the Team and then on the basis of 'best fit' with consumer need and worker skills, knowledge and expertise.
- Workers will manage a heterogeneous and diverse caseload with consumers at various points on the "care pathway".
- Workers with recognised specialist skills will be involved in the provision of care without needing to be the sole worker involved.

- The allocation of work will occur at team level rather than solely in consultation between the worker and their supervisor.
- All members of the team will participate in decisions made about case allocation, case management and key worker assignment.
- The process of allocation will occur on a daily basis and is reviewed via a team clinical review meeting held weekly.
- A transparent process will be used to review progress for all active consumers as part of the weekly team meetings. For example, the 'Zoning Board' model implemented in some districts in New Zealand has merit in ensuring the best fit of skilled resource available and consumer need.
- On a 3-monthly basis, a formal review of the Consumer Care Plan is undertaken with the consumer, carer and significant others involved.
- Caseload capacity is identified within the team for the provision of crisis and emergency response, including after hours response
- The team manager will take an active role in the management of incoming service demand, the worker allocation process and prioritisation of response
- CMHC team staff will work across both hospital and community settings. A proactive focus will be placed on in-reach services to Emergency Department (ED) services and the creation of alternatives to ED's being a first or recurring point of entry into the service system

3.5 Key Worker Functions

- To be the primary contact point for a consumer, the point of navigation assistance, and the person to whom the consumer can return for assistance in resolving issues with the service system
- To support, assist, advocate, broker, mentor and to provide the point of continuity for the consumer across coordinated services
- To ensure that a comprehensive assessment is undertaken, which forms the basis for the care plan
- To develop an individual care plan with the consumer, outlining their goals strategies and responsibilities
- To facilitate implementation of a consumer's care plan
- To review the care plan with the consumer at least every 3 months
- To ensure that appropriate arrangements exist and to facilitate the transfer of care within public mental health care services when required
- To promote and assist the consumer to develop self-management skills

3.6 Consumer Allocation and Review Process

Team based reviews will occur for the following purposes:

- Daily Team Review – This mandatory central meeting explores team based clinical support, the allocation of new referrals, and assessment of status of current crises and the necessary implications to resource allocation for individuals and the team. It requires a transparent review of the status of each clinician's case load, which

- Clinical reviews – all services delivered to each consumer in respect to their needs and goals will be peer reviewed at a minimum every three months in accordance with National Mental Health Standard 11.3. This review will be part of, or an input into, the operating level review referred to in 6.2.2. These peer reviews will be informed by a prior scheduled (e.g. weekly) review which ideally will involve the active participation of the consumer (National Standards for Mental Health Services 11.4), the Carer (Carers Recognition Act 2005), the designated care coordinator / key worker and any other relevant parties including but not exclusive to NGOs, consultant psychiatrists and GP's (National Standards for Mental Health Services 8.2 and 8.3)¹⁹. Hence the peer review with the multidisciplinary team will occur as a parallel process and in addition to the direct review occurring with the consumer present.

3.7 NGO Responsibilities at Sector Level

Refer also to the IPRSS and other NGO Models of Care.

Under this Adult Community Model of Care, non-government sector agencies will provide a range of support functions consistent with individual need, which will form an integral component of a networked team of skilled practitioners engaged in supporting the individual's recovery. SA Mental Health has well-defined and accepted processes for the delivery of NGO services.

There are clear advantages to NGOs working within the catchment area of their nearest Community Mental Health Centre, however, where a specific NGO service is not provided within their local CMHC area, consumers will be supported by consistent and transparent processes to ensure that no detriment to service occurs.

NGOs, like any other agency, can act as centres of excellence for a specific service or technique across more than one Sector.

3.8 Safety and Quality in Operation

The Community mental health services will operate under the safety and quality principles and priorities described within the *South Australian Mental Health and Wellbeing Policy (draft)* derived from the National Standards for Mental Health Services, Australian Council for Healthcare Standards, the National Safety Standards, and Key Performance Indicators for Australian Public Mental Health Services.

These safety and quality priorities will include the development of a *Mental Health Safety and Quality Framework* for the implementation, evaluation and continuous quality improvement within community mental health services in line with national and state policy directions. The *Framework* will delineate the aims of high quality care in terms of safety, effectiveness, and patient-centred, timely, and efficient care domains, and include the agreed national and state performance indicators for community mental health services.

Priorities to ensure consistent, safe and evidence-based practice in mental health service delivery under the *SA Mental Health and Wellbeing Policy* the following clauses must be addressed across all CMHCs and the wider mental health care service system:

Consumer and community participation

- Ensure that consumers are informed and involved in safety and quality programs, ensuring that feedback on service is provided to health professionals and that consumers are involved in the planning and delivery of services and service improvement strategies.
- Ensure information about outcomes of care and the performance of the health care system is shared with health care providers and the public.

Governance and accountability

- Develop and implement a comprehensive *Mental Health Safety and Quality Framework* incorporating national safety priorities in mental health.
- Ensure good governance structures are put in place, decision-making is transparent and there is clear accountability for the delivery and continuous improvement of services.
- Ensure that resources are used appropriately and responsibly
- Ensure effective complaints management processes are put in place and addressed.
- Ensure that appropriate processes are in place for the management of adverse events.

Monitoring and Evaluation

- Ensure that services are monitored and evaluated across the continuum of care to ensure that the best possible health care is provided to people with mental health problems or a mental illness.
- Ensure that safety and quality audits and risk assessments are undertaken
- Ensure that monitoring systems are based on measurable standards, with appropriate benchmarking and outcome measures.

Physical Health and Wellbeing

- Prioritise the physical health and wellbeing of people with severe mental illness, ensuring that their physical health is assessed and monitored and that they receive evidence-based medical care, particularly where physical health problems are associated with the use of psychotropic medication to treat a mental illness.
- Increase the understanding of the relationship between physical health and mental health across primary and specialist health care services and in the general community.
- Ensure intervention for co-morbid physical health conditions incurs at the onset of illness, with a particular focus on the physical health needs of young people experiencing early psychosis, including diet, exercise and lifestyle education and support.

Safe use of medicines

- Ensure the use of medications has a sound evidence base and takes into account potential side effects and other adverse reactions that may affect a person's mental and physical health needs and is in compliance with relevant policies and procedures governing the use of medication.
- Clear documentation and record keeping of all medication treatment history, and current medication regimes
- Reduce and eliminate where possible the use of multiple psychotropic medications in the treatment of people with psychosis.

- Facilitate partnerships between general practice and mental health professionals in relation to the medical treatment of people with a mental illness to achieve the highest possible standard of care and consistency of treatment regimes.
- Support further research and the collection of accurate data on the use of medications to inform policies and procedures governing the best practice use of medications.

Reduce adverse events, suicide and deliberate self harm in mental health services

- Ensure mental health assessments, including risk assessments and physical health assessments are conducted and in a timely manner
- Ensure the recommendations and strategies are incorporated into consumer care plans
- Ensure risk management and care plan strategies are communicated with all involved in the care of the consumer are consistently implemented
- In the event of an adverse incident involving a registered mental health consumer such as suicide or serious suicide attempt, the community mental health team are also responsible to communicate with the consumers' family and carers and offer/provide them with appropriate mental health support services.

Safe and appropriate transport

- A range of transport options are considered to ensure that appropriate, respectful and least restrictive practices are adopted in transporting consumers for the purpose of facilitating treatment

ENDNOTES

1. South Australian Social Inclusion Board (2007). *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*.
2. Honeyman, M. et al (2008). *A Review of Community Mental Health Services in South Australia*, p26.
3. Anthony, W. A. (1993). *Recovery from mental illness: The guiding vision of the mental health service system in the 1990's*. *Psychosocial Rehabilitation Journal*, 16(4), 11-23.
4. Davidson, L. (2004, April). *Recovery: Challenging the Paradigm*. Key Note Address presented at the 6th Biennial VICSERV Mental Health Conference, Melbourne, Victoria.
5. Country Health SA (2006). *One country: One system of mental health care for country South Australians [Paper]*.
6. US Department of Health and Human Services. (2004, December). *National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation*. Retrieved June 4, 2008, from the University of Illinois at Chicago Department of Psychiatry website:
<http://www.psych.uic.edu/uicnrtc/cmhs/consensus.draft14.pdeIVecchio.doc>
7. SA Health. (2008, Month). *South Australia: Our Health and Health Services*. Retrieved June 4, 2008, from the SA Health website:
<https://www.library.health.sa.gov.au/Portals/0/south-australia-our-health-and-health-services.pdf>
8. Wilcock, A. (1998). *An Occupational Perspective of Health*; Slack, Thorofare.
9. *NHS Health Development Agency (2005). Partnerships*. Retrieved June 4, 2008, from the NHS Health Development Agency website:
<http://www.renewal.net/Documents/RNET/Policy%20Guidance/Partnerships.pdf>
10. Department of Health (2006). *Emergency Services Memorandum of Understanding*. Retrieved June 4, 2008, from the SA Health website:
http://www.health.sa.gov.au/mentalhealth/DesktopModules/SSSA_Documents/LinkClick.aspx?tabid=36&mid=351&table=SSSA_Documents&field=ItemID&id=23&link=mh_housing_mou.doc
11. Department of Health, South Australia (2007) *Housing Memorandum of Understanding* available at:
http://www.health.sa.gov.au/mentalhealth/DesktopModules/SSSA_Documents/LinkClick.aspx?tabid=36&mid=351&table=SSSA_Documents&field=ItemID&id=23&link=mh_housing_mou.doc
12. Department of Health Child *Protection Information Exchange Protocol* (2007)
13. Houlst, J., Reynolds, I., Charbonneau-Powis, M., Weekes, P., & Briggs, J. (1983). *Psychiatric hospital versus community treatment: The results of a randomised trial*. *Australian and New Zealand Journal of Psychiatry*, 17, 160-167.
14. Framework for Health (Reference Unavailable).

15. Department of Health Government Publishing Service *A recovery oriented framework for adult mental health services in South Australia* (2008)
16. South Australia Mental Health Bill 2008 (2008). Retrieved June 4, 2008, from:
<http://www.legislation.sa.gov.au/LZ/B/CURRENT/MENTAL%20HEALTH%20BILL%20008.aspx>
17. Council of Australian Governments (COAG). (2006). National Action Plan on Mental Health 2006-2011. Retrieved June 4, 2008, from:
http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.rtf
18. Thornicroft, G. & Tansella, M. *Components of modern mental health services: a pragmatic balance of community and hospital care; overview of systematic evidence*, *British Journal of Psychiatry*, pp 282-290
19. National Standards for Mental Health Services (1996) (AHMAC) Australian Government Publishing Service.

APPENDIX 1: EXAMPLE OF A ZONING BOARD MODEL

Clinicians' names run across the top row									
A Thick Red Line									
A list of consumers who are either in hospital (red magnet next to their names), in crisis or have been referred to the acute team.									
A thick Amber line									
Consumers with early warning signs and at point of relapse – have been seen, reviewed and a clear plan in place – basically a client of concern picture for after hours clinicians.									
A thick green line									
Consumers receiving routine care and divided up according to frequency of input									
A thick green line									
Consumers working towards discharge									
Black									
Consumers who are out of area or another agency (e.g. prison) – there is an expectation that they will be returning.									

APPENDIX 2: RECOVERY

Recovery refers to the ways in which a person with a psychiatric disorder manages his or her disability in the process of reclaiming his or her life in the community.

Recovery-oriented care refers to what psychiatric treatment and rehabilitation practitioners offer in support of a person's recovery.

Recovery is not a term for what the service system does *to* or *for* people with mental illness. Rather, it will refer to people taking advantage of opportunities and utilising the supports and services/tools he or she needs in order to be successful in the ordinary life tasks of loving, working, playing, and belonging. It is the responsibility of the system to ensure that options exist to facilitate and support individuals in their recovery (Davidson, 2004⁴; CHSA 2006⁵).

The key building blocks of recovery have been identified as:

- Belonging and acceptance from caring others
- Renewed hope and commitment
- Involvement in meaningful activities in the community
- Redefining the illness as only one aspect of a multidimensional sense of self (rather than having ones self and life defined by the illness)
- Incorporating illness
- Finding ways to manage the symptoms
- Overcoming stigma
- Assuming control, experiencing successes and pleasure
- Empowerment, reciprocity and giving back to, and regaining citizenship in, the broader community (Davidson, 2004⁴)

Recovery is an orientation that has at its core an acceptance that the individual is always capable of change - to adapt, conquer, surpass; to amend, control, and express their individuality and unique contribution to their own lives and those of others. A recovery approach orientation provides prompts to ask the questions which invite the consumer to participate as a citizen - to fully participate in their own life and to accept increasing responsibility in influencing *their* life experience.

A useful definition that has resonance to those that experience mental illness (and often referenced) is that proposed by Anthony (1993³):

'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.'

A somewhat broader definition also emphasises the importance of recovery as a journey, but with the ability to heal and be transformed by the experience - or even in spite of it:

'Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.' (USNCC, 2004⁶)

Although a focus on recovery is fundamental to the provision of mental health services, the team will recognise two vital areas of difference between individual consumers:

1. each individual's recovery journey, and realisation of recovery, is different;
2. the illness stage at which each individual becomes receptive to working towards recovery differs.

The recovery focus in turn relies upon a number of related principles, which will be used by the team in assisting consumers in their individual journeys of recovery:

- **Self Directed** – Consumers lead, control, exercise choice over, and determine their own path of recovery by optimising autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Non-linear** – Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognises that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths Based** – Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The consumer moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support** – Mutual support, including the sharing of experiential knowledge and skills and social learning, plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect** – Community, systems, and societal acceptance and appreciation of consumers - including protecting their rights and eliminating discrimination and stigma – are crucial in achieving a place of wellness. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility** – Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must seek to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope** – 'Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalised; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Consumer Centred

The consumer is our *raison d'être*. The services we provide are directed by the needs of the consumer - the consumer is the focal point for our service delivery and everything we do must be capable of justification on the basis of meeting consumer need, facilitating the individual's recovery and supporting them in their journey.

We believe in the uniqueness of the individual and the importance of our service system's ability to meet individual needs. The state of mental health and wellbeing is an immensely personal state of being. Our service system, and in this context our community mental health services, must be capable of responding to an individual's needs and to take direction on the basis of those needs. For example, we need to resist the way of working in which we rely solely upon a narrowly determined diagnosis, so that we always look at the person as we would expect to be treated.

Consistent with this belief is the engagement of consumers at each level in the decision-making process. Service planning, policy development, operational management procedures, service protocols, inter-agency agreements, memoranda of understanding, service delivery provisions - all are the province of consumers to contribute to and influence. "Nothing about us without us."

Holistic

Clearly, a focus on mental health and well-being ('a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity') requires not a focus on the signs of disease, but rather on the person in the context of their social and cultural environment. We seek to support people with their natural supports and we do not seek to replace them with a health care-based support structure. Our focus needs to be on what the consumer states is their support structure, not one imposed on the basis of what we think the support structure should look like.

Empowerment

Consumers have the authority to choose from a range of options and to participate in all decisions - including the allocation of resources- that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organisational and societal structures in his or her life.

Prevention, Early Intervention

A key principle of the Community Mental Health Service is that effective preventive and early intervention measures, coupled with sound primary health care, will minimise the need for crisis, acute and emergency actions. To this end, the team will follow these strategies, and will encourage consumers, GPs and partner agencies to do likewise.

Partnership with Family and Significant Others

The service works in partnership with consumers and their family in the least restrictive way and commits to the premise of not "doing for" but "doing with", and seeking to ask the questions that help the person to learn more about themselves and their initiative.

APPENDIX 3: LITERATURE REVIEW

Community Mental Health Service Structures

CHANGE

Change in the delivery of mental health care has escalated in the last four decades, more so than in other parts of the health system. More than a century of the 'rise of the asylum' (Tansella, 2005), since the late 1950's, large mental hospitals have been dramatically reduced in size or closed. Across Australia, the number of psychiatric inpatients per 100,000 population has reduced from 400 to less than 50. (Rosen, 2001).

In South Australia, inpatient numbers peaked at about 2900 in the early 1960's, most of the subsequent reduction occurred in the 1970's and early 1980's. Some early de-institutionalisation was actually 'trans-institutionalisation' as separate facilities were established for people with intellectual disability and as older inpatients moved to nursing homes.

However, many people moved to community accommodation as hospital beds closed. Large, older residences were converted to boarding houses or units; in the 1960's and 1970's, such buildings were able to be used for relatively cheap accommodation.

SERVICES

Numerous studies have replicated Hoult's work in Sydney (1980), including work at the Maudesley in London (1994). These demonstrate that acutely unwell patients can often be managed at home, with outcomes at least as good as hospital care. The 'training in community living' program developed during the 1970's in Wisconsin, USA (Stein 1980) was the model for assertive community treatment. The Team for Assessment of Psychiatric Services (TAPS) has shown that with appropriate services and re-provisioning, long-stay patients discharged from psychiatric hospital can thrive (Leff, 2000).

Across the developed world, re-investment in community services has not matched reductions in hospital care, (Leff, 2001). Cost-effectiveness studies on de-institutionalization and of community mental health teams have demonstrated that quality of care is closely related to expenditure. (WHO, 2003)

The literature on evaluation of community care addresses overlapping issues of effective delivery of interventions and delivery of effective interventions – sometimes confusing the themes.

EFFECTIVE DELIVERY OF SERVICES

SERVICE ORGANIZATION

For developed, high-resource countries, there is some agreement, though at times limited evidence, about core functions of CMH services (WHO, 2003). Effective services address both health and social services.

Case management has been well established as a major component of mental health services in most developed countries for over twenty years.

Studies of case management teams cover a wide variety of service arrangements, target groups and workforce mix. Inherited from the days of large-scale de-institutionalization, the core function of the case manager was to help a consumer navigate the myriad of agencies necessary for community living and mental health treatment – previously provided by the hospital.

As community based services have developed, comparing 'standard case management' with often similar 'treatment as usual' groups have sometimes shown little benefit (Marshall, 1998). This argument is further supported by Simmonds (2001) who concluded that case managed community care appears preferable to hospital care.

Evidence suggests that maintaining a better contact with consumers is one clear outcome of case management.

There is a significant literature and debate about conflicting reported results, concerning Assertive Community Treatment teams (ACT). The general conclusion is that well structured ACT is of proven benefit for the most disabled community clients (Rosen, 2001, Guddeback, 2006).

Asserting styles of intensive case management are effective in reducing the number of days spent in hospital and improving engagement with services, compliance, independent living skills and client satisfaction (Marshall, 1998).

Rosen (2001) has questioned whether combining ACT with community crisis team functions in some studies of ACT has reduced the effectiveness of the latter.

APPENDIX 4: BIBLIOGRAPHY

Adapted from NHS Health Development Agency (2005). *Partnerships*. Retrieved from: <http://www.renewal.net/Documents/RNET/Policy%20Guidance/Partnerships.pdf>

Care Services Improvement Partnership, Royal College of Psychiatrists & Social Care Institute for Excellence (2007). *A Common Purpose: Recovery in future mental health services*. Retrieved June 4, 2008, from the Social Perspectives Network website: http://www.spn.org.uk/fileadmin/SPN_uploads/Documents/Papers/SPN_Papers/recovery2.pdf

Department of Human Services Victoria (2008). *Because mental health matters: A new focus for mental health and wellbeing in Victoria – Consultation Paper* May 2008. Retrieved June 4, 2008, from the Victorian Department of Human Services website: <http://www.health.vic.gov.au/mentalhealth/reformstrategy/mhmatters-rep08.pdf>

Gerrand, V. et al (2007) '*Reforming mental health care in Victoria: a decade later*' *Australasian Psychiatry* 15; 181 – 184

Guddeback, G. et al (2006) '*How many assertive community treatment teams do we need?*' *Psychiatric Services* 57; 1803 – 1806

Healthcare Commission, UK (2007) '*No voice, no choice; a joint review of adult community mental health services in England*' Commission for Healthcare Audit and Inspection

Helbig, K. (2006, November). *Rational for Clinical Rehabilitation Programs*, Unpublished paper.

Helbig, K., Mansfield, J. & Cafuta, R. (2007, August). *Occupational Therapy Functional Assessments*. (Unpublished paper)

Hoult, J. et al (1983) '*Psychiatric hospital versus community treatment; a controlled study*' Department of Health, NSW

Leff, J. & Trieman, N. (2000) '*Long-stay patients discharged from psychiatric hospitals; Social and clinical outcomes after 5 years. The TAPS Project 46*' *Brit J Psychiatry* 176; 217 – 223

Leff, J. '*Why is care in the community perceived as failure?*' *Brit J Psychiatry* (2001) 179; 381 – 383

Lingwood, L. (2005). *Redesigning Mental Health Day Services: A modernisation toolkit for London*. Care Services Improvement Partnership. Retrieved from: http://www.socialinclusion.org.uk/publications/redesigning_day_services.pdf

Marks et al (1994) Home-based versus hospital based care for the severely mentally ill' *Brit J Psychiatry* 165; 179 – 194

Marshall, et al (1998) *Case management for people with severe mental disorders*, in The Cochrane Database of Systemic Reviews, 1998 Issue 2

Marshall, M. et al (1999) '*PRISM Psychosis Study: Design Limitations, questionable conclusions*' *Brit J Psychiatry* 175;501 – 503

Marshall, M. Lockwood, A (1998) *Assertive community treatment for people with severe mental disorders* in The Cochrane Database of Systemic Reviews 1998, Issue 2

Phillips, S. et al (2001) '*Moving assertive community treatment into standard practice*'
Psychiatric Services 52; 771 – 779

Rosen, A. & Teesson, M (2001) '*Does case management work? The evidence and the abuse of evidence-based medicine*'. ANZJ Psychiatry 35; 731-746

Social Inclusion and Recovery, Julie Repper and Rachel Perkins, Bailliere Tindall, February (2003), cited in Development Centre for Mental Health Care Services Improvement Partnership, 2005. Sainsbury Centre for Mental Health, London

Social Inclusion Unit (*undated – copy available*). *Mental Health Reference Group: Psychiatric Disability, Housing, Rehabilitation and Support Services*.

Simmonds, S. et al (2001) *Community mental health team management in severe mental illness; A systematic review*. The Cochrane Database of Systematic Reviews 1998 Issue 2

Stein, L.I., & Test, M.A. (1980). *Alternative to mental hospital treatment*. 1. Conceptual model, treatment program and clinical evaluation. *Archives of General Psychiatry*, 37:4, 392-397.

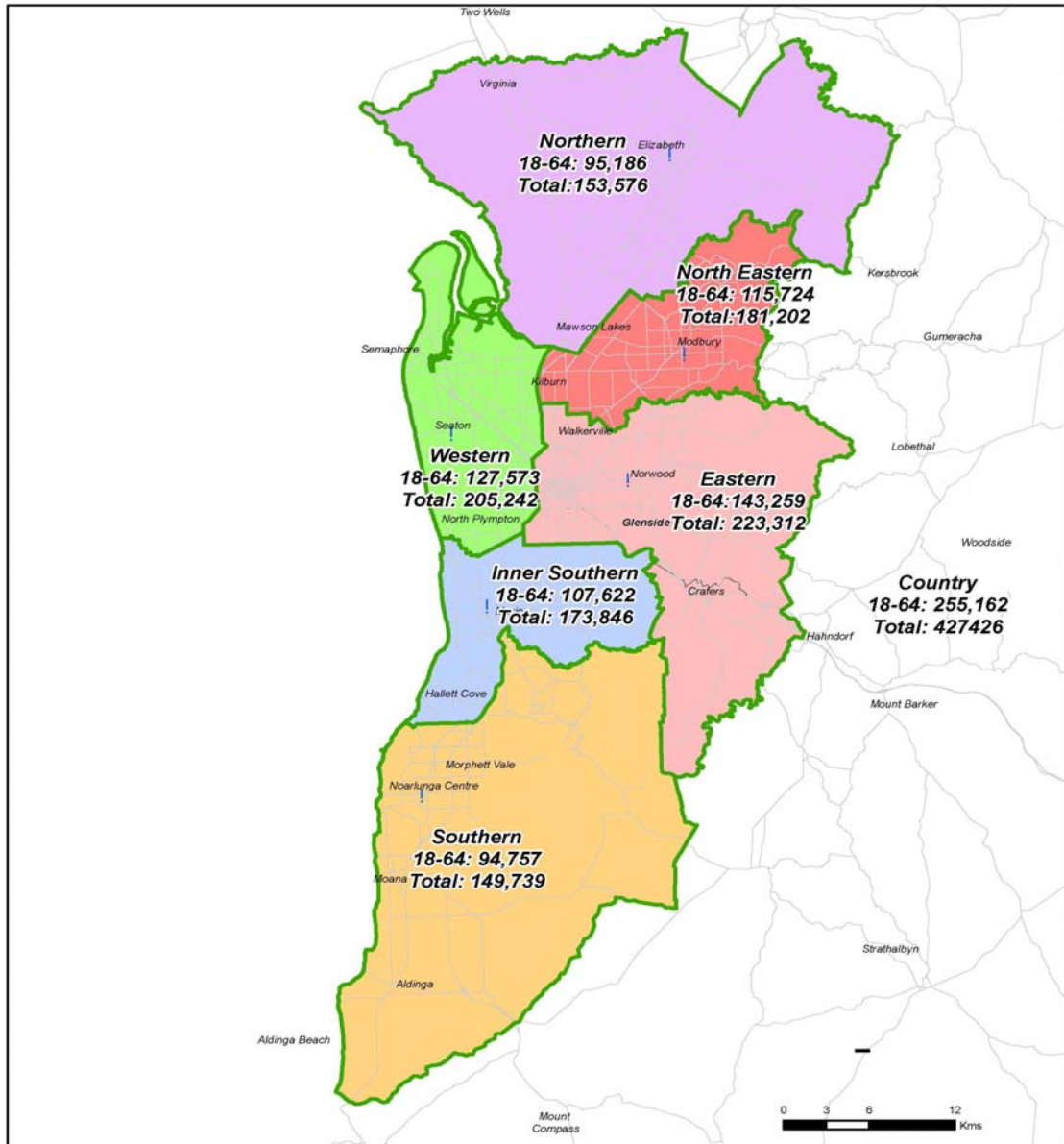
Tansella, M. et al (2005) '*Evaluating a community-based mental health service for severe mental illness. The Verona experience*' Acta Psychiatrica Scandinavica (Supp 429) 90 – 94

Thornicroft, G. et al (1998) '*PRISM Psychosis Study 10: from efficacy to effectiveness in community mental health services*' Brit J Psychiatry 173; 423 – 427

WHO Health Evidence Network (2003) "*What are the arguments for community-based mental health care?*" WHO Regional Office for Europe

APPENDIX 5: SECTOR MAP

**2006 Population by Region
Totals and 18-64 years**



- ! Proposed sites (estimated)
- ▭ New Regions
- Main Roads

The information and material displayed herein are an information resource only and whilst all reasonable care has been taken in its preparation, the Department of Health does not make any representations or warranties as to its accuracy or otherwise. The Department of Health excludes all liability and loss whatever its cause and to whomsoever arising directly or indirectly from its use.

Produced by:
Information Management
SA Health
Client data: CBIS, Mental Health Unit
10/12/2008
Data have been supplied using SLA
Print Date: December 2008

