Country Health SA LHN

Mental Health Services

Community Mental Health Model of Care

DRAFT

December 2016

Government of South Australia

SA Health

Version Control

Version	Release Date	Change	Author	Approved
V1	14/11/16	Incorporated input from MoC Working Groups	Julie Deane	
V2	13/12/16	Changes to structure based on Steering Committee feedback	Julie Deane	
V3	16/12/16	Included link to Youth and Older Persons MoS Included assertive medication management Change to workforce introduction Included Crisis Response Pathways	Julie Deane	
V4	20/12/16	Changes based on Steering Committee feedback	Julie Deane	

Document Review Date: As required

Disclaimer

No responsibility is accepted by Country Health SA Local Health Network for any errors or omissions contained within this publication. The information contained within the publication is for general use only. No liability will be accepted for any loss or damage arising from reliance upon any information in this publication.

ACKNOWLEDGEMENT

Country Health SA acknowledges the guidance and assistance provided by all the participants involved in the CHSA Community Mental Health Model of Care Steering Committee, Reference Group, Working Groups and Flinders Rural Health SA (Flinders University).

Table of Contents

OVERVIEW

Country Health SA Local Health Network (CHSALHN) is proud to be transforming health care to deliver benefits for rural and remote South Australians. Our mission is to impact meaningfully and positively on the communities we serve and to be a flourishing mental health service. Our intention is that every contact will strengthen a person's wellbeing, mental fitness and engagement with life.

This framework is intended as a guide and should not limit the creativity or flexibility of individuals or teams in solving problems for the benefit of people who use our service. This Model of Care has been based on service responsiveness to consumer and carer need and is to be read in conjunction with the Youth Mental Health Model of Service and the Older Persons Mental Health Model of Service.

Country Health SA has adopted the following five foundation principles to guide the implementation of the strategic plan.

Person Centred Care is the primary focus

We will

- involve our consumers in making decisions about their own health care and how health services are provided for their community
- integrate and coordinate multiple services so that individuals receive seamless health care
- ensure consumer safety and wellbeing

Innovation

We will foster and embrace innovation, based on emerging evidence, in an effort to continually improve health care.

Sustainable Investment

Our services will be sustainable, effective, affordable and minimise waste.

Local Presence, Central Strength

We will work as one single country health service, while being recognised as many valued local health services.

Vibrant Safe Workplaces

Our workforce will know where we are going, and will be supported and inspired to go there.

Country Health SA Mental Health – an integral part of country communities

Country Health SA Mental Health staff live and work in country communities, and we strive to provide the best services possible for our communities. We engage and communicate with stakeholders and community members in flexible and creative ways. We value relationships with people who are living and working in each unique rural setting.

Rural communities in South Australia are prone to major natural disasters. Therefore, an important consideration is how the community mental health service will assist communities to prepare and recover from drought, fires and floods. We will aim to collaborate across sectors of the community to assist communities to develop resilience and recover from disasters.

Our model of care is informed by research that demonstrates care should focus on well-being through:

- early intervention and crisis response;
- clinical management of physical health and chronic disease;
- comprehensive care planning;
- therapeutic interventions that take advantage of e-health and mental health services in partnership

with non-government organisations and general practitioners; and

- community reintegration.

Our model of care has been designed to engage consumers and carers from different cultural backgrounds and we will support staff development and training to enable appropriate delivery (Flinders Rural Health SA, 2016). It will remain responsive to emerging evidence based practice and research.

Resilience and Wellbeing

In developing this model of care, we wish to shift the resilience and wellbeing focus from a deficit based view to a strength based view.

This approach is consistent with the Integral Theory which emphasises the importance of adopting multiple perspectives and solutions in approaching any challenges one may confront.

By consciously paying attention to the consumers' needs from multiple perspectives, we wish to actively engage them in partnerships to improve their health outcomes and self-agency.

Please see the appendix for further details of the Integral approach.

PERMA +

Moreover, our work is done in a larger context of South Australia aspiring to be a Wellbeing State based on PERMA + principles as articulated by South Australian Health and Medical Research Institute's (SAHMRI) Centre of Resilience and Wellbeing.

Perma + = **P**ositive Emotions
Engagement
Relationships
Meaning/Purpose
Accomplishments/Achievements

Plus + **=** Sleep, Nutrition, Exercise and Optimism.

We seek to promote these building blocks of positive emotional, social and physical wellbeing throughout the organisation.

Workforce Development and Support

CHSALHN recognises that continual development of the workforce is necessary to create an environment where service excellence can flourish.

We recognise that the skill, capacity, knowledge and values of our staff have a direct correlation with the effectiveness of our work with consumers and their carers. As an organisation we are, therefore committed to:

- Listening to staff about their experiences and continuing to review the effectiveness of services and the impact on other parts of service provision;
- Developing practice hubs for clinicians;
- Providing multi-disciplinary leadership in practice development, service planning, training, supervision and support for staff; and
- Ensuring that this Model of Care is an evolving document that is updated in response to

experience, reconsidered and renewed when needed, and used as a vehicle for sharing good practice.

Demographic Context

Country Health SA LHN delivers mental health services to 983,776 square kilometres which is 99.8% of SA, making it the biggest Local Health Network in Australia. CHSALHN Mental Health, services a population of 445,607. According to Australian Bureau of Statistics, Census data 2011, the total population of South Australia is 1,596,569. Over 50% of Aboriginal people, who have high rates of mental health issues, reside in country. 75.5% of the 40 most disadvantaged Statistical Local Areas are in country South Australia.

E-Health and the use of Technology

Where possible, CHSALHN Mental Health will engage with and advocate for relevant people friendly technologies. The use of technology is critical to our clinical services to cover the vast geographic areas. We will:

- use DTN technology to offer access to specialist assessment and intervention to supplement what can be offered locally and to connect people's networks into therapeutic conversations.
- provide accessibility to the service, connections to people's networks; ongoing engagement with service providers, and opportunities for feedback
- ensure as much as possible that the service is responsive, accessible and there is equity of outcomes
- govern all use of technology through privacy and safety principles.

E-mental health services are cost-effective, accessible, available in rural areas, and supported by the Australian Government. E-mental health services will be integrated with CHSALHN Mental Health Services (MHS), with the development and application of referral pathways. All clinical staff in CHSALHN MHS will be involved in training and evaluation of their use of e-mental health services in day-to-day practice, using best practice guidelines and available resources such as the e-Mental Health in Practice Project (eMHPrac).

Our Business

Country Health SA Local Health Network Mental Health helps country people experiencing functional disability due to mental illness in their recovery. As a specialist mental health service aiming to maximise the opportunity for people to manage their mental health condition, we work in partnership with consumers, carers and community services to access the right level of care based on our expert assessment, treatment, review and to facilitate community integration.

Links

This document references the following key documents which outline the overarching objectives and principles for the delivery of mental health care services in South Australia:

- Adult Community Mental Health Services (Metropolitan Regions) Model of Care, 2009
- Country Health SA Local Health Network Mental Health Services Model of Care 2010
- Country Health SA Local Health Network Older Persons Mental Health Model of Service
- Country Health SA Local Health Network Youth Mental Health Model of Service, 2014
- Mental Health Act 2009 and Plain Language Guide to the Mental Health Act 2009

- The South Australian Carers Recognition Act 2005
- South Australia's Mental Health and Wellbeing Policy 2010-15South Australian Mental Health Services Pathways to Care Policy Directive 2014
- National Practice Standards for the Mental Health Workforce, 2013(4)
- National Standards for Mental Health Services, 2010(5)
- Mental Health Services Working with Aboriginal and Torres Strait Islander People - Learning Guide Edition 2, 2014(6)
- A National Framework for Recovery-Oriented Adult Mental Health Services in South Australia (draft) 2013 (7)
- South Australian Rehabilitation & Recovery Framework
- A Framework for pharmacists as partners in mental health care, 2013 (8)

This document will require ongoing monitoring and development through a consultation review process and an ongoing review to meet the needs of our consumers.

1. RECOVERY

The Recovery model has been widely adopted and is perhaps the most pervasive model for mental health service delivery in Australia. Recovery is presented as a social construct focused on hope, acceptance, community connectedness, self-determination, shared decision-making and peer support (O.K. Burmeister & Marks, 2016, p. 173)**.**

The concept of recovery describes a person's own unique and personal journey to create a fulfilling, hopeful and contributing life and achieve his or her own aspirations, despite the difficulties or limitations that can result from the experience of mental illness. It does not necessarily mean the elimination of symptoms or a return to a person's pre-illness state (South Australia's Mental Health and Wellbeing Policy 2010-2015 - Available on the SA Health website)**.**

This approach to recovery emphasises that everyone who experiences mental illness, including those seriously affected by mental illness, can achieve an improved level of wellbeing and a renewed sense of identity, purpose and meaning in their life in the presence or absence of symptoms of illness.

In the service delivery context, the recovery approach requires mental health services to actively engage in a flexible partnership with people experiencing mental illness, their families and carers in concert with other agencies, to encourage and empower a person doing their own work towards a more fulfilling, hopeful and contributing life (South Australia's Mental Health and Wellbeing Policy 2010-2015).

The use of language

There is ongoing debate regarding reference to those in receipt of a mental health service. While "participant" is becoming more appropriate, not all people are willing participants. This document largely refers to the service group of people as "consumer" and is intended with respect and understanding of the diverse experiences of all individuals regardless of their level of participation.

This website discusses this topic further http://www.ourconsumerplace.com.au/helpsheet?id=3563

Trauma Informed Care and Practice

Country Health SA Mental Health recognises that there is a large body of knowledge about the impact of

traumatic experience on a wide variety of psychological, physical & social problems. We understand the major role of trauma in the development of emotional disorders and medical and mental illnesses (Bloom & Farragher, 2011). As a service we acknowledge the need to understand the prevalence, impacts, and states of trauma to adequately support those with lived experience, families and communities. Therefore, our staff will implement a 'trauma informed' approach with all of the consumers with whom we work.

We need to presume the clients we serve have a history of traumatic stress and exercise

'universal precautions' (Hodas, 2006).

We will provide a respectful practice that avoids re-traumatisation and incorporates choice as a core component of our work.

Trauma Informed Care and Practice is a strengths-based framework grounded in an understanding of, and responsiveness to, the impact of trauma. It emphasises physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment.

2. INTEGRATED SERVICE PROVISION

In an integrated service or team, every staff member is responsible for their own contribution. They work collaboratively with others in the team and, together, they are responsible for the provision of a range of clinical and related services to a defined population. The workforce comes from a range of clinical and non-clinical roles, including:

Nursing
Social work
Medical
Psychology
Occupational therapy
Aboriginal health workers
Administration staff
Psychosocial support workers
Peer support workers

Consumers and their carers are part of our decision making team

The teams have a range of recovery-focused functions, including the delivery and coordination of emergency assessment, crisis intervention, clinical care and support. While there is an emphasis on coordination of care, teams provide therapeutic interventions within a multidisciplinary model.

In addition to their discipline specific skills, knowledge and understanding of the Mental Health Act 2009, all clinical staff are required to have a core set of skills in the following areas:

- Therapeutic engagement through skilful communication
- Mental State Examination & risk assessment and management
- De-escalation of aggressive incidents
- Care planning
- Family and Carer involvement
- Community engagement and Primary Health care principles
- Early intervention and preventative strategies in the relapse of, or emerging severe mental illness.

3. LEADERSHIP

Leadership and Governance

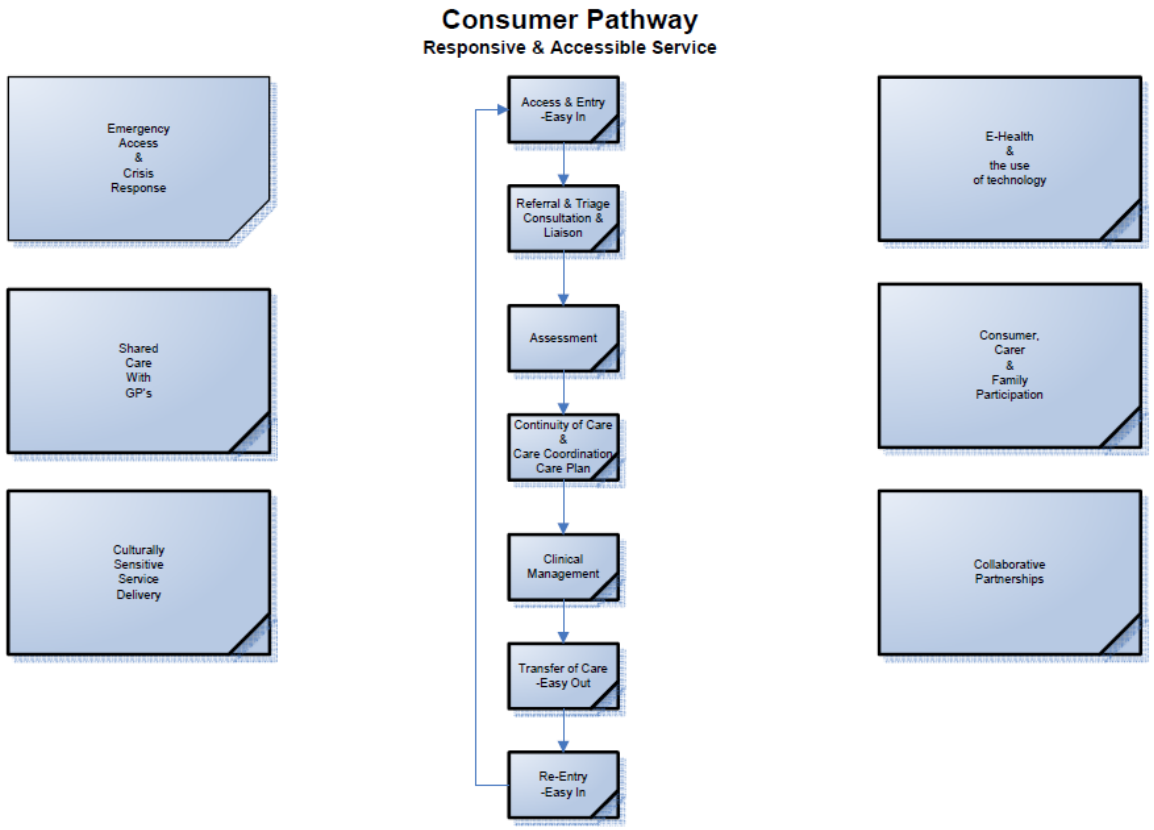
Services are managed as a single service delivery system. There is clear accountability for corporate and clinical governance systems and processes designed to ensure consistency in service quality, access to care and standardised approaches to core business.

Clinical governance is the system by which the governing body, managers, and clinicians share responsibility and are held accountable for consumer safety, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care (Australian Council on Healthcare Standards).

4. CONSUMER PATHWAY and RESPONSIVE DELIVERY of CARE

The World Health Organisation defines health as "a state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity"

This definition emphasises that mental health is an inseparable part of a person's holistic well-being, together with physical and social health accordingly must be recognised in the coordination of care.



4.1 Access and Entry

"Any door is the right door" – regardless of where consumers and their carers choose to access mental health services, all staff will ensure access to the right support at the right time.

"Easy in – easy out" – consumers will be able to access services easily and transition to more appropriate services seamlessly and/or exit after receiving quality services.

The Multidisciplinary Team has responsibility for ensuring consumers are receiving the right care in the

right setting.

4.2 Clinical Referral Process

- Referrals are addressed according to clinical priority.
- At the point of first contact, the Mental Health Service gives consumers and carers a contact name and team phone number. The assigned clinician becomes the key point of contact throughout the journey.

4.3 Consultation and Liaison – Approach with General Practitioners, Health and Community Services

The distances between services and communities in country South Australia, and the lack of on-the-ground specialist services, has necessitated creative and innovative approaches to service delivery. The use of telemedicine technology is the most significant example of this.

The Model of Care relies heavily on close working relationships at the local primary health care level with the support of metro-based specialist staff using the Consultation–Liaison (C-L) approach. The C-L approach is already a well-established feature of our service and strong partnerships exist with all local services across country South Australia. We maintain access to specialist input across Country SA, as well as linking metropolitan tertiary service components, regional General Hospitals, local country mental health services and other primary care services. This is particularly important with implementation of the *Mental Health Act 2009*.

The four major objectives in the C-L approach are:

> facilitate a seamless integrated mental health service for South Australia

> provide consultative support to enhance the ability of locally-based care providers to appropriately care for consumers within their own community. Local health care providers remain actively involved in the ongoing care of consumers, even if that care is transferred to Adelaide or other location

> enhance general practitioners and other primary care worker's skills in the detection and management of mental illness. The mental health team members may provide some direct clinical services with the main aim of providing guidance to the GP. There has been an emphasis on changing specialist psychiatric input from clinical 'hands on' work with small numbers of consumers to the C–L approach. In this way, routine psychiatric care is delegated to professionals outside the specialist mental health service, reserving direct clinical work in the service to the most complex and problematic presentations

> improve outcomes for consumers and their carers.

4.4 Assessment

The Team Manager/Team Leader or delegate will identify the staff member to undertake the assessment based on skill, capacity and consumer need.

Individuals will be assessed regardless of physical or intellectual disability, co-morbid substance use or the presence of any other medical condition – factors of complexity indicate a clinical priority.

Mental state examination is a core component of each person's contact.

4.4.1 Clinical Risk Assessment and Management

Our genuine care and concern for the wellbeing of consumers will include the implicit consideration of risks. A formal, explicit risk assessment is a systematic and objective approach that enables us to manage

identified or potential risks. Risk awareness however should not cloud the therapeutic orientation towards the consumer and a mindset towards holistic care will prevail.

4.5 Crisis Response

Local Community Mental Health Teams are available to respond to referral enquiries, intervening assertively where required.

Mental Health Teams will always endeavour to facilitate treatment in the least restrictive environment by keeping people in their home or community through the provision of assertive and intensive outreach practices to avoid Emergency Department presentations and acute admissions. Mental Health teams will work under the guidelines of a comprehensive risk management process.

1. A community team will respond:
    a. When a person or family member contacts the team for assistance
    b. When a person walks in to a CMHT facility requesting assistance
    c. When ETLS requests a Face to Face Crisis assessment or response to a crisis phone call.
2. If a community team is unable to respond they will:
    a. Refer the person on to either ETLS, GP or local hospital for assessment and assistance
    b. Request ETLS to contact local hospital, GP, SAPOL or SAAS if a face to face crisis assessment is required.
    c. Follow up with the consumer as soon as possible after the initial crisis contact.

The Emergency Triage & Liaison Service (ETLS) operates 7 days per week, 24 hours a day to provide a liaison and consultation service, available to those aged 16 years and above with an urgent mental health related concern in the rural and remote communities of South Australia. ETLS provides a crisis service to new referrals and after hours crisis support to existing consumers of the mental health services, links people to the appropriate level of care when required, and organises multi agency responses. ETLS has a vast knowledge of community and health services across country South Australia, coordinates specialist services and overall maximises resilience and wellbeing to keep people safe in their community.

4.6 Continuity of Care and Care Coordination

The key to a recovery-oriented mental health service is helping consumers to find the right combination of services, treatments and supports. It also means removing barriers to full participation in work, education and community life.

4.6.1 Co-ordination of Care

Where continuing involvement of the Community Mental Health Team is indicated, a clinician is designated as responsible for the consumer's care and provides continuity as the face of the service. Staff from a range of other disciplines may also be involved in providing assessment, care planning and interventions. This may include:

- Direct contact with the consumer and their personal clinical network in the provision of appropriate intervention and therapy.

- Ensuring the right service partners are involved in the care and intervention planning. Facilitating the flow of information to and from other providers involved in the delivery of services.

The Care Coordinator is the central point of accountability for the delivery of service and will undertake

- Completion of assessment/diagnostic formulation
- Initiation and development of the care plan with clear identification of who is involved in care and their specific roles and arrange a case conference as required
- Identification of changing needs for support and ensuring an appropriate team response
- Social support/interventions in collaboration with other providers as appropriate
- Short term crisis management where indicated and safe to do so
- GP and agency shared care and partnership processes. Shared care with GPs is a central part of the Care Coordinator role and once the consumer is exited from the service the GP will be supported to take the lead in the ongoing care.
- Coordination / facilitation of pharmacological interventions and relevant information. Including assertive medication management, if required.
- Oversight and promotion of metabolic / physical health screening and management
- Completion of the clinical review according to national and state standards and assist with psychiatric review process (DTN or face to face)
- Offer or provide education on preventative strategies that contribute to a least restrictive approach and promotion of self-management
- Connection of the consumer to lived experience / peer support worker
- Advocacy and promotion of mental health and the reduction of stigma
- Transfer of care planning at the point of admission to the service.

4.7 Mental Health Care Plan

The care plan is the contract or map of care that describes the priorities of care, where the consumer wants to be or wants to achieve, and how we/they are going to reach these goals (with identified persons responsible). Care planning is conducted with the consumer, their family and service partners in consultation with the multidisciplinary team.

The four stages of the Care Planning Process are:

1. Priority or agreed issue
2. Achievable goal
3. Measurable actions or interventions
4. Evaluation /review – this may lead to further iterations of the plan

Principles

Care plans should be seen as one process which 'meets' the person where they are on their journey. In some cases this will mean that we take the lead in providing care, such as for those consumers who are acutely unwell and unable to care for themselves. In this case the priority of care may be limited to maintaining needs such as safety and security. Other consumers will work with the clinician to develop their care plan, taking ownership of it and responsibility for working towards their goals.

The care plan continuum

Working with the consumer on this continuum allows us to be flexible in our approach. The continuum is

not linear, but instead recognises that individuals have changing levels of resilience depending on internal and external stressors.

4.8 Shared Care with General Practitioners

Shared care with GPs can improve mental and physical health outcomes with improved social function, self-management skills, service acceptability reduced hospitalisation and facilitate a smooth transition of care at discharge. Other benefits include improved access to specialist care, better engagement with and acceptability of mental health services.

4.9 Physical Health and Chronic Disease Management

Looking after physical health is an extra challenge for consumers who also have a mental illness. This may be related to the symptoms of the illness or the side-effects of medication. Consumers of our service may smoke, not get enough exercise, or experience other lifestyle factors. It is important that physical health problems do not get overlooked when the focus is on treating a mental illness.

We bring awareness in every contact we have by initiating discussion around the plus of perma – sleep, diet and exercise. We role model the behaviours we want to cultivate in the consumers of our service.

The role of caring for physical health is led by GPs; they should retain an overview of the patient's health state and are responsible for prevention and treatment of somatic illness. We develop and build strong collaborative partnerships with local GPs, provide an interface between the GP and the consumer, advocate for consumers to ensure they are receiving regular metabolic management, appropriate medication management and chronic disease management. We work together with GPs, exchange information and provide and receive education.

The links below provide further information.

http://nnswlhd.health.nsw.gov.au/wp-content/uploads/Looking-after-Your-Physical-Health-when-you-have-a-Mental-Illness.pdf
http://www.iphys.org.au/

4.10 Consumer, Carer and Family Participation

CHSALHN Mental Health Services has developed a 2 year plan with the intent to promote consumer and carer involvement in the service and equip teams with the knowledge and resources to do this.

Below are the goals of the plan:

INFORM GOAL: Current consumers of CHSAMHS and their families, and community members know where they can come for care and what to expect. People who use our services and their carers and families know how to give feedback about their experience and how we perform against national, state and service standards.

CONSULT GOAL: People who are directly affected by our services are given a range of mechanisms to let us know how those services are received and perceived. They then receive feedback about their input and its impact.

INVOLVE GOAL: People will be directly involved in their own care and those of their loved ones, and in the way that services are provided.

COLLABORATE GOAL: We will partner with consumers and carers in individual care as much as possible to ensure maximum exercise of choices, rights and freedoms and joint decision making; we will work with local representatives and individuals to design appropriate service models.

EMPOWER GOAL: To maximize possibilities for decision making by consumer and carers, both independently and jointly with CHSAMHS staff.

4.11 Culturally Sensitive Service Delivery

We will ensure that cultural competency and safety are embedded in all aspects of service delivery.

Community Mental Health Services will:

- Operate within the *SA Health Cultural Respect framework and Cultural Inclusion frame work.*
- Ensure that staff undertake appropriate cultural awareness and competence training.
- Identify and work with appropriate cultural consultants from local communities and service providers.
- Integrate cultural awareness into case reviews, and discussion and clinical supervision.
- Use professional interpreters, where needed and agreed to, to ensure all family members are heard and understood.

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people experience a range of health challenges attributable to the ongoing impact of colonisation and socio-economic factors. MHS will work with local Aboriginal Health Services to support the individual, families, community health and wellbeing initiatives that address the complex interaction of social, cultural, economic and physical environments in which Aboriginal and Torres Strait Islander people live. Aboriginal and Torres Strait Islander People have continuing rights and responsibilities as custodians of their land associated with traditional ownership and as members of kinship groups and families.

Culturally and Linguistically Diverse (CALD) Background

At every point of contact, services will be respectful of the cultural, linguistic, religious, spiritual and other specific needs of people from CALD backgrounds. Additionally, consumers, families and communities of CALD backgrounds are welcomed as active partners in the planning and development of culturally competent mental health care services.

We collaborate with cultural consultants, community-based organisations and other partners, in working with individual consumers, where this is agreed, appropriate, and in the consumer and family's best interests. The MHS will also seek advice and information from these organisations to ensure that services are accessible and appropriate and effectively promoted.

We recognise and respond to the particular needs of refugee people whether with their families or unaccompanied.

Currently, CHSALHN MHS staff attend cultural awareness training provided by the local health service. We are committed to ensuring standardised cultural awareness training for all MH staff. CHSALHN MHS will ensure that the organisation will assess the cultural safety of policies, procedures, strategies, service delivery and individual mental health team sites.

4.12 Clinical Management

Therapy and Treatment

Therapy functions as the application of skills and evidence based treatments available to all consumers within the team. There are a variety of therapeutic interventions provided by clinicians within the team and the Distance Consultation Service.

4.12.1 Provision of increased pathways to specialised services

The approach to our work with consumers is to respond to the whole person, in her/his context with the fullest possible collaboration.

Every contact with our service should contribute to recovery and resonate positively in our absence.

Clinicians, consumers and interested others regularly review effectiveness of particular therapeutic approaches and adjust care plans and provision accordingly.

All staff adopt a therapeutic approach , that is respectful, inclusive and include the elements of PERMA.

All clinicians provide targeted therapeutic interventions in line with their professional and post graduate

training.

CHSAMHS is committed to targeted recruitment, training, supervision and quality assurance/clinical governance to build staff capacity.

The service provides evidence based therapeutic interventions tailored to the needs of the consumer and family whilst also encouraging innovation, both in the development of therapeutic interventions for people experiencing significant mental health problems and in enhancing access through the use of technology.

4.12.2 Clinical Review

The Team Manager/Leader in partnership with the Regional and or Team Psychiatrist ensures that a system is in place for clinical review with the multidisciplinary team.

Key components of clinical review

- Review of the assessment, outcome measures, care plan, identification of consumer status and current issues, review of congruency between outcome measures and care plan, identification of risk issues, shared care arrangements with GPs and NGO input for psychosocial rehabilitation
- Discussion with consumer, family member/carer, other agencies, GP etc. small multi-disciplinary meeting, documentation
- Assess the readiness of consumer for transfer to a primary care provider or other community services for ongoing care.
- Comprehensive case conference – Formal and extensive care plan review conducted with consumer, carer, relevant agencies involved with care and GP.
- High/complex needs case conferencing.

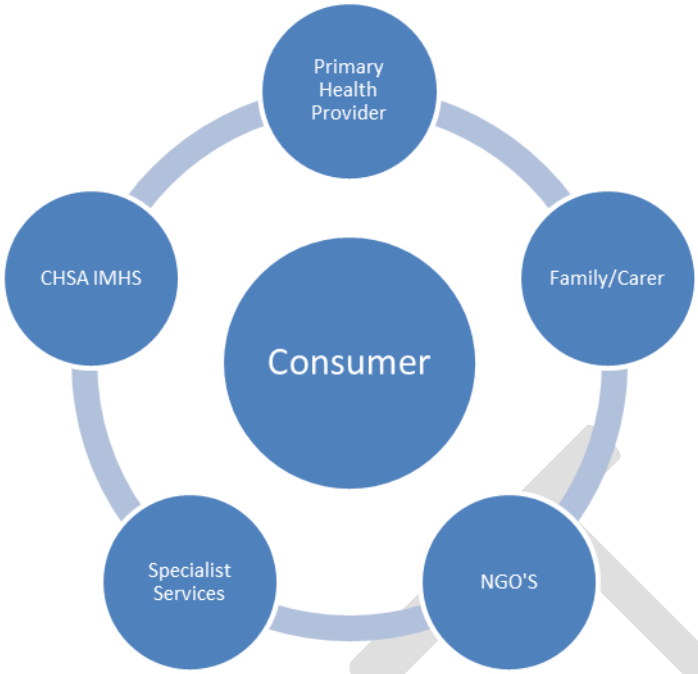
4.13 Collaborative Partnerships to Promote Integrated Service Delivery

Mental Health Services have formal interagency agreements with Emergency Services[1] and with Housing SA[2].

[1] Mental Health and Emergency Services, Memorandum of Understanding, 2010. Available on the SA Health website.

[2] Mental Health and Housing Memorandum of Understanding, 2010. Available on the SA Health website.

Partnerships and Collaboration



Principles of our partnerships:

Clear and Transparent Communication

- At all transition points, discharge, stepped up/down transitions, clinical recommendations
- Timely and accurate information
- Feedback at referral points
- If "wrong door" support to navigation to the "right door"
- CHSA leads facilitation of local partnership forums to enable CHSA to have a clear knowledge of services available to meet the needs of consumers. Where possible the inclusion of GP's and Practices potentially through email bulletins.

Clear role definition

- Clarity of CHSA service provision – tertiary focus
- Primary care role support i.e. GP "whole of life" clinical lead with specialist clinical input from CHSA
- All CHSA staff are aware of formal partnerships and their role and commitment to same
- Ensuring required and appropriate service partners are involved in the care and intervention planning and delivery process through care plan development, review and monitoring.
- Acknowledgement of skills, experience and value in consumers life

Inclusiveness

- Carers and families are engaged with and included in all transition points and planning
- Partners are identified at all transition points and engaged in planning processes
- Communication is responded to in a timely and appropriate way
- Discharge from CHSA is undertaken collaboratively with all identified partners

Value of expertise

- Collaborative planning to ensure that elements of care planning are met by the most appropriate partner
- Early identification of expertise in care planning

Common aim/Consumer Centred

- Consumer at the centre of partnership/collaboration
- Recognition that all partners have common goal
- Consumer inclusive care planning

4.14 Outcome Measurement

Outcome Measures are mandated for mental health services and are undertaken according to national protocol. Outcomes are an integral part of routine clinical practice.[3]

4.14.1 Outcome Measures

The primary measure of outcome is feedback from the consumers, their families and service partners. Each team will have mechanisms in place to gain feedback, and report on service enhancements that flow from it. Practitioners use standardised measures of changes and outcomes for mental health consumers.

4.14.2 Outcome Safety and Quality Systems

CMHS are required to meet mental health standards and comply with those listed below, which is in addition to any other legally required standards:

- *Australian Council of Health Care Standards*
- *Commonwealth Department of Health and Aging: National Standards for Mental Health Services*
- *Accreditation process with the Quality Improvement Council (QIC).*

4.14.3 Key Performance Indicators (KPI)

Key Performance Indicators will be developed using the CMHS destination of every contact will strengthen a person's wellbeing, mental fitness and engagement with life. Every contact a person has with CMHS will make a difference. Key Performance Indicators have been set in a service level agreement with SA Health and are aligned to Australian Institute of Health and Welfare KPI's for Australian Public Mental Health Services.

4.14.4 Health Information and Data Collection Systems

The collection of health information is extremely important to adequately capture activity across all services, Community Mental Health Teams record all episodes opened, including ETLS, to ensure we meet Community Mental Health Care National Minimum Data Set specifications. For reporting purposes all multi-disciplinary assessments and intervention are recorded.

We use electronic information systems for community mental health and form a central electronic repository for demographic and clinical information, contributing to funding needs and outcomes. The system provides a record of current assessment, care planning and service contacts, preventing duplication for consumers and carers. Our system enables 24 hour access to electronic documentation to read and/or record aspects of care, facilitating effective co-ordinated care.

[3] National Outcomes and Casemix Collection. Available online: http://amhocn.org/

4.14.5 Documentation

Clinicians are responsible for medical record documentation with an emphasis on electronic input for up-to-date individual care. Oversight for the quality of medical record documentation and it's compliance with relevant policies[4] rests with Team Manager/Leader.

4.15 Transfer of Care and Exiting (Easy Out)

At every transition point there is an opportunity to reduce impact for consumers.

This section describes the principles for dealing with the transition points in a consumer's journey. At every transition there is the potential to either improve the outcome for the consumer, or negatively impact their recovery journey. If transfer of care is from an Inpatient Unit, the consumer will be allocated a Community Mental Health Care Coordinator before any discharge planning occurs and the Care Coordinator will be included in all aspects of the planning.

The overarching aim of our service is to maximise our consumers opportunity for early community reintegration and for the service to be able to intervene early in the illness relapse cycle.

Principles:

Consumer/Family Engagement and Activation

- Consumer at centre of transition planning.
- Engagement of consumer and family/others in care planning process, care transitions.
- Identification of consumers holistic needs i.e. physical health, housing, employment, financial and referral to appropriate supports.
- Carers and families are engaged in transition planning.
- Carers and families are encouraged to continuing their relationship and respective roles while the consumer is an inpatient.

Clear and transparent communication

- All relevant partners will receive a copy of the discharge plan.
- Partners are invited to contribute to transition planning.
- Consumers and carers are provided with contact information and person responsible for care input.

Medication Management

- Medication management will be discussed with consumer/family at each transition point to ensure safety, accuracy and appropriateness of medication therapy and to encourage shared understanding about issues, such as barriers for use by consumer.

Comprehensive Transition Planning

- Clear and timely communication with all partners (family, support networks, GP).
- Identified goals, actions and responsibilities.
- Consumer appropriate Relapse Prevention Planning which is shared with family, support networks and GP.
- Discharge planning begins at commencement of admission to service and includes the consumer's support network.

[4] wiki.health.sa.gov.au/Country/3-Whole_of_Country_Services/Mental_Health/Policies_Procedures

- At every transition point the consumer's support network will be communicated with to assist with identifying any potential barriers, supports required and input.

4.15.1 Clinical Handover

The SA Health ISBAR process of Clinical Handover is followed to promote transfer of professional responsibility and accountability for some or all aspects of care to another person or professional group.

A system of handover while clinicians are on leave is managed by the Team Leader and Clinical Practice Consultant.

4.16 Re-entry (Easy In)

There will be no barriers to re-entry and Electronic Records follow the consumer (No retelling of history by consumer or carers). Staff will always be responsive to consumer and carer requests for variation in the level of care. If a previous consumer contacts ETLS/Mental Health Triage, depending on the clinically assessed urgency; the triage service will refer the consumer to the original team for contact and the previous Care Coordinator will be re-allocated for continuity of care. This is the same if the consumer/carer/family contacts the team directly, even if it is a one-off phone call it will be directed to the previous Care Coordinator and will only be followed up by the duty worker if the Care Coordinator is not available.

Re-assessment of known consumers will be done only as clinically required; existing information will be accessed and updated where possible.

5. RECOMMENDATIONS

There will be a Service Delivery Model developed informed by this MOC to enable consistent implementation.

6. REFERENCES

Adult Community Mental Health Services (Metropolitan Regions) Model of Care, April 2009. Available on the SA Health Website: www.sahealth.sa.gov.au

Bloom, S L & Farragher, B, 2011, *Restoring Sanctuary: A New Operating System for Trauma Informed Organizations*, New York, Oxford University Press

Burmeister, O. K., Marks, E., 'Rural and remote communities, technology and mental health recovery', Journal of Information, Communication and Ethics in Society, (2016) 14(2), pp 170-181

Code of Ethics for the South Australian Public Sector, February 2010. Available from Commissioner for Public Sector Employment website: http://www.espi.sa.gov.au/

Country Health SA Local Health Network Mental Health Services Model of Care 2010 *LINK*

Flinders Rural Health SA, 'Narrative Literature Review of Community Based Mental Health Service Strategies: A resource for the newly established CHSA Model of Care Working Groups', October 2016

A Framework for pharmacists as partners in mental health care, 2013

A Framework for Recovery-Oriented Adult Mental Health Services in South Australia, April 2013

Hodas, G, 2006, *Responding to childhood trauma: The promise and practice of trauma-informed care.* Harrisburg: Pennsylvania Office of Mental Health and Substance Abuse Services

Kegan, R, Lahey, L, 2001, *Seven Languages for Transformation,* San Francisco: Jossey-Bass

Mental Health and Emergency Services, Memorandum of Understanding, 2010. Available on the SA Health Website: www.sahealth.sa.gov.au

Mental Health and Housing Memorandum of Understanding, 2010. Available on the SA Health Website: www.sahealth.sa.gov.au

Mental Health Act 2009. Available online at www.legislation.sa.gov.au

Mental Health Care Plan Information Booklet, SA Health, 2009. Available from the SA Health Intranet: http://inside.sahealth.sa.gov.au

Mental Health Services Working with Aboriginal and Torres Strait Islander People - Learning Guide, Central Northern Adelaide Health Service, April 2008.

National Outcomes and Casemix Collection. Available online: http://amhocn.org/

National Practice Standards for the Mental Health Workforce, 2002, p7. Available on the on the Department of Health and Ageing Website: http://www.health.gov.au

Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services, UK Department of Health, 2007. Available from www.nationalarchives.gov.uk

South Australia's Mental Health and Wellbeing Policy 2010-2015. Available on the SA Health Website: www.sahealth.sa.gov.au

Test and Stein 'Alternative to mental hospital treatment: conceptual model, treatment programme and clinical evaluation' *Archives of General Psychiatry*, 1980, v37, p392 – 397

'The use of the Health of the Nation Outcome Scales (HoNOS) to inform discharge and transfer decisions in community mental health services' *Australian Health Review*, Feb 2009.

http://www.ourconsumerplace.com.au/consumer/index

7. GLOSSARY

Some Acronyms Used in Mental Health	
ACSC	Associate Clinical Service Coordinator (level 2 Nurse managerial)
A/H	After Hours
ACHS	Australian Council on Healthcare Standards
ADIS	Alcohol and Drug Information Service
AHP	Allied Health Professional
AHPS	Authorised Health Professionals
AMHOCN	Australian Mental Health Outcomes and Classification Network
AMP	Authorised Medical Practitioner
ANMF	Australian Nursing & Midwifery Federation
ATC	Approved Treatment Centre
BAS	Bed Allocation System
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CBIS	Community Based Information System
CCCME	Country Consolidated Client Management Engine
CCTV	Closed Circuit Television
CHSALHN	Country Health SA Local Health Network
CLCA	Criminal Law Consolidation Act
CN	Clinical Nurse (level 2 nurse clinical)
CNP	Clean Needle Program
COAG	Council of Australian Governments
COP	Code of Practice
CPC	Clinical Practice Consultant (Registered Nurse level 3 clinical)
CRW	Community Recovery Worker
CSA	Client Services Assistant
CSC	Clinical Service Coordinator (Registered Nurse level 3 Managerial)
CTO	Community Treatment Orders
CVS	Community Visitor Scheme
CYWHS	Children, Youth and Women's Health Service
DASSA	Drug and Alcohol Services South Australia
DCLS	Distance Consultation Liaison Service
ECT	Electroconvulsive Therapy
ED	Emergency Department
EPAS	Enterprise Patient Administrative system
ETLS	Emergency Triage and Liaison Service
HCSCC	Community Services Complaints Commissioner
HONOS	Health of the Nation Outcome Scale
HV	Home Visit
ICC	Intermediate Care Centre
ICT	Information and Communication Technology

ICU	Intensive Care Unit
IDDI	Illicit Drug Diversion Initiative
IPRSS	Individual Psychological Rehabilitation Support Services
IPU	Inpatient Unit
JNH	James Nash House
KPI	Key Performance Indicator
LGA	Local Government Area
LLG	Local Liaison Groups
LSP	Life Skills Profile
LTC	Limited Treatment Centres
MHA	Mental Health Act
MHLO	Mental Health Legal Orders
MHU	Mental Health Unit
MIFSA	Mental Illness Fellowship of South Australia
MO	Medical Officer
MOU	Memorandum of Understanding
NGO	Non-Government Organisation
NOCC	National Outcomes Casemix Collection
OCP	Office of the Chief Psychiatrist
OPMHS	Older Persons Mental Health Services
PBS	Pharmaceutical Benefits Scheme
PICU	Psychiatric Intensive Care Unit
PSA	Patient Services Assistant
R&R	Rural & Remote
RANZCP	Royal Australian New Zealand College of Psychiatrists
SAAS	South Australian Ambulance Service
SAMHTC	South Australia Mental Health Training Centre
SAPOL	South Australia Police
SASMOA	South Australian Salaried Medical Officer's Association
TCAC	Treatment Centres Advisory Committee
TOR	Terms of Reference
TQEH	The Queen Elizabeth Hospital
WCH	Women's and Children's Hospital
WHO	World Health Organisation

8. APPENDIX

Resilience and Wellbeing – building multiple 'capitals'

Our work is delivered in accordance of the CHSA performance framework of an integral approach. This means, in short, paying attention to **mindsets, relationships, behaviour and systems.**

By transforming **mindsets** consumers will feel like they can author their own life, feel supported and respected by the system, and confident to articulate their own needs.

By transforming **relationships** (personal, familial, organisational, professional, etc) consumers are in equal and active partnership to promote their health.

By transforming **behaviours** consumers will pay attention to life rhythms and habits (mental and behavioural), including sleep, diet, exercise, medication adherence and purposeful action.

By transforming **systems** we are building an integrated, holistic view of consumers' needs that create / support self agency.

We are shifting our focus from deficit to value. In doing so, we support the creation of multiple 'capitals' – the Meta Capitals approach, a concept borrowed from other industries:

In our consumers we:

Increase their **knowledge capital** by

Education/learning about concepts of mind, physiology (for instance physiology of anxiety), mind-body connectedness, the current health and social systems and by sharing experiences

Increase their **psychological capital** by

Reducing, in a measurable way, distress levels and symptom burden and increasing capacity for self compassion and sense of wellbeing

Increase **spiritual capital** by

Helping each person to gain a clearer sense of their individual gifts and purpose and supporting them to find a place to express those gifts

Increase **health capital** by

Producing measureable improvements in health outcomes including physical fitness, weight, metabolic health, rates of substance abuse and life expectancy

Increase **human capital** by

Developing life skills, (communication, social, self-organisational, financial), employment skills

Increase **social capital** by

Connecting with others that have similar interests and needs

Increase **cultural capital** by

Inviting feedback from consumers to services to learn how to meet the consumers' needs best and utilising peers to support others in their healing.

Engagement with all stake holders as a learning community

Increase **financial capital** by

Access to resources and maintenance, pathways to vocational opportunities as means to generate income.

Increase **natural capital** by

Connection to the land (not limited to Aboriginal people).