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Mr David Morris
Chief Operating Officer
Southern Adelaide Local Health Network (SALHN)
Flinders Medical Centre, Level 2
Flinders Drive
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Dear Mr Morris

Re: SALHN Mental Health (MH) – Draft Adult Community Mental Health Model of Care (CMH MoC)

The Public Service Association (PSA) writes to provide feedback on behalf of PSA members in relation to the draft Adult CMH MoC.

The PSA received numerous comments from members at members' meetings and by phone and e-mail, and now provide this feedback below.

Specific feedback is as follows:

1. It is noted that the draft MoC does not refer at all to the Deloitte Report into Adult Community Mental Health, into which all members had input and which contained a wide range of recommendations. Although it is acknowledged that following the release of the report and recommendations, SA Health moved all development and implementation associated with MoCs down to Local Health Networks (LHNs), members believe that the report and recommendations should still be referred to. Without this, they feel it will be just another report and recommendations that will be forgotten like previous ones have been; and that issues that were identified through that work are left unresolved again.

2. Related to the above, the PSA and members' understanding of a MoC is that it should identify and prioritise issues for change. There is no acknowledgement by SALHN of the key issues that have been repeatedly raised by members and outlined again and again across multiple recent service reviews. These include:

- a focus towards clinical pathways that are "congested and crisis driven", resulting in an imbalance between acute and non-acute resources and programs within CMHS
- the majority of CMH clients are in non-acute phases of care and do not get equitable service time and intervention quality
- the significant variation across the community mental health service in the types and durations of service a client may receive, depending on the team philosophy
- the variation in the interpretation and adoption of Recovery Principles in mental health care, with a tendency for the service to manage an 'illness' or a 'focus of care' rather than people, their recovery and preventing further/ future deterioration

- reduced accountability at transfer of care
- client re-entry to the service is predominantly through presentation to an Emergency Department
- varying levels of effective partnerships and co-operation from other services to support desired client outcomes; and
- suboptimal levels of client and carer engagement and communication from the community mental health services. This is often accompanied with consumer and carer frustration with the lack of choices given in relation to their care, understanding what type of services are available from the CMHS, and in having to navigate multiple structures to obtain co-ordinated care.

Members are concerned that for all the effort going into MoC development these are not being addressed for the benefit of staff and clients. It would be depleting for staff to undergo a reform process and then endure further reviews where the same issues persist and continue to get raised.

3. While members understand the data that is included in the MoC, they believe it would be useful to include information regarding client and carer experiences - for example, what is known about their experiences, what they see as their needs and what they currently find positive and most helpful. This includes the specialist needs of Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CALD) people; and Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LBGTQI) within the SALHN catchment. Members want to see services and planning that is getting the best outcomes for clients, and appreciate learning from clients and carers to best do this – hence this is critical information for helping to guide and engage staff.

4. Members are also concerned that there is no reference in the document to prevention and education strategies - for example, partnering with other services, across all sectors and categories of provider, to deliver education around prevention. If the expert clinicians in public sector mental health do not undertake this critical work, members question who will.

5. Under Part 4, "Our Consumers", there is a list of only three groups of people that SALHN states will receive *"...Specialist Adult Community Mental Health Services..."*. PSA members are extremely concerned that the following groups will not receive a service according to the draft MoC:

- People experiencing first episode, prodromal, or an acute episode of psychosis
- People experiencing situational crisis or episodes associated with personality disorders.

Members believe that these groups must be included. It is not known at that time if the person will develop a *"severe and/or persistent disorder"* or a *"long term disorder"*, nor will the person necessarily be at risk of significant harm to self or others. However, specialist assessment, treatment and early intervention is required to assist with better client outcomes and to prevent an escalation of risk.

Related to the above, members also commented that there is no reference to the need to address the psychosocial determinants and circumstances which have led to a psychiatric emergency, and which perpetuate illness (ie. housing, conflict, grief, psychological crisis) - the domain of Allied Health.

Members also note that the Deloitte report identified six groups of people who *"need ongoing specialist, community mental health care"*. This section has removed the following three groups of clients from this list as requiring services:

- Where the level of support exceeds primary care team offerings
- Disorders requiring skilled or intensive treatments not available in primary care
- Complex problems and multi-agency requirements

Members are interested to understand SALHN's rationale for this.

In addition, under this section and/or under section 6.4, PSA members seek that there is reference to "eligibility criteria" and this is being consistent across all LHNs. This was raised by members in terms of concerns if clients move to other areas, and are told that the particular care/"service" is not available in the other LHNs. This "consistent criteria" may need to be discussed with other LHNs and if so, the PSA would seek that these discussions occur rather than gaps in client care being present in other areas.

6. Members note the sections, both under Part 4 and Part 5, that discuss Aboriginal and Torres Strait Islander people; CALD people; and LBGTQI people. They also note within those sections it is stated that effective engagement is required with these groups. However, members believe that there must be a much a stronger commitment stated in the MoC, as it seems as if data and statistics are quoted but not a clear statement that specific focus will be given to these areas when the Service Plans are developed.

7. Many members also expressed concern with the comment on page eight stating the reasons for Aboriginal and Torres Strait Islander (TSI) people presenting to CMHS at higher rates than non-Aboriginal/ TSI people are related to either being a reflection of service access or higher prevalence of mental disorders. This evidences a dismissal of the many psychosocial variants listed above which see many Aboriginal/ TSI people involuntarily, homeless, having strained relationships with families as a consequence of their mental illness, and more often to decline and re-present to CMHS in higher rates than the non-ATSI population of SALHN. Hence the relatively higher rates of contact by population. This needs to be redressed in the MOC.

8. The first sub-heading under section 6.3 is *"Holistic, Consumer Centred and Multidisciplinary Lead Care"*. The PSA and members seek that "Mutlidisciplinary" is expanded, to document the range of disciplines that fall into this category, so that all readers, including clients and carers, have the same understanding in terms of this group.

9. Numerous comments have been received under section 6.4:

- The PSA refers to dot point two above and the feedback regarding *"eligibility criteria"*, which may also apply to this section as well.
- The reference to *"multi-disciplinary teams"* in the first paragraph of this section needs to be inserted under both the Acute Care and the Non-Acute Care sections, so that all readers are aware that multi-disciplinary care exists in both "streams".
- Under *"Acute Care Services":*
    - The first dot point states that a key function of Acute Care is to *"Provide a centralised, co-ordinated mental health triage 24/7"*. The PSA and members seek further clarification in regard to this statement, given that a centralised Mental Health (MH) Triage already exists, based currently with CALHN MH. Is it the intention of SALHN MH to have their own Triage service? If not, this dot point needs to be amended to refer to this being in regard to the current centralised MH Triage.
    - This section refers to individuals who have significant levels of psychosocial disability. However, there is nothing contained in this section that refers to the support of this psychosocial disability, and holistic care that includes psychosocial interventions to support people with these issues or while in a situational crisis.
    - Related to the above, Strategic Direction Four of the SA Mental Health Strategic Plan states that services should be *"person-centred and recovery oriented."* There is no mention of recovery oriented services, or a focus on aiming to assist clients to self-manage with this focus on recovery. It is felt that this section is medicalised, yet recovery focus should begin with the first intervention.
    - It is also stated that the acute care service will provide timely intervention, and will be as determined by individual patient requirement. The PSA and members believe that there needs to be a stronger emphasis on client-led care, and that all disciplines will be available within the acute team so that the client is able to access whatever intervention is required, from whichever discipline needs to provide that intervention, in a timely manner.
- Under *"Non-Acute Care Services"*, the fourth dot point includes reference to clients requiring higher intensity (including level of contact, range of interventions/services) treatment; and also discussed work with other services and joint care planning etc. Members believe there needs to be a stronger emphasis regarding the care with those clients who are high risk and have multiple service providers involved in their care, due to the many barriers and issues in supporting those clients currently.

10. Members would like confirmation in the MoC document that the list of interventions under section 6.5, *"Therapeutic Interventions"* would be available across both the acute and non-acute services, with the most skilled clinician providing that intervention.

11. Under section 6.5, *"Pathways to Care"*, members note that service access etc. will be detailed in the service plan. However in relation to *"...influenced and impacted by other care providers..."*, members believe there needs to be some mention of this being influenced and impacted by the capacity and service match with other care providers. Members are very aware of the impact of NDIS matters and also reduced/ceased funding to some NGOs by state and federal governments, and that this must be acknowledged so that the MoC is realistic in relation to these matters.

More general feedback is as follows:

1. The direction and principles which underpin the Model:

- Under *"Legislation, Policy and Frameworks"* there is a list of what the MH Services (MHS) are 'governed by'.
- Several of these documents are key national and SA strategic reforms, agendas and plans, and are not policies, laws and accreditation requirements that SALHN is governed by.
- Members consider these national and SA MH strategic plans as exciting opportunities for dients, staff, innovation and promising much needed positive MHS reform.

  However members are disappointed and concerned that SALHN makes no commitment to the values and reform expectations established by the fifth National Mental Health Plan, the SA Mental Health Commissioner's MH Strategic Plan, and the National Mental Health Commissioner's 2014 Contributing Lives Review and 2017 National Report on Mental Health and Suicide Prevention. The National Mental Health Commission isn't even referred to here.

  Similarly the core values, principles and reforms set out by these documents are also not reflected or evidenced in the MOC. Members are concerned that SALHN is deciding to move away from the reforms that are consistently being promoted and progressed in all other parts of the MHS across Australia and this is unsettling.

- The Service Mission and Aim statement provides no vision. The National Safety & Quality in Health Care Standards mandate partnering with consumers as an Accreditation standard.

  Statements like "*your life matters to us*" naturally leads to the inference this new aim is because the service is coming from a place where "*your life <u>didn't</u> matter to us*". There are a lot of existing CMH practices (particularly care planning and care plan reviews) which staff know are not designed to be/not always delivered in a way which is dient inclusive - and members want to see these change. But partnering with dients has not occurred because "*your life didn't matter to us*".

  As members who have chosen health care professions and dedicate their time and effort to doing the best for clients, they feel that this mission statement is demeaning. It is equally concerning that staff would be expected to present this mission statement to dients and other services.

  As an effective, responsive public health service it is inherent for the service that dients' lives "*matter to us*". For it to be stated with pride that this is something new and innovative is embarrassing to members as health care professionals.

- The listed Values are service centric, vague and contestable in meaning. Other MHS MoCs do not include sections like this.

  Allied Health (AH) members are disheartened to see a MoC that is not client oriented in its values.

- Some Social Workers commented that the Value "*We empower people*" is fundamentally incompatible with their professional values, social work training in social theory, and education in Recovery-Oriented care. They feel that it is a top down statement which reinforces that the

service believes it holds power and has an ability to *'empower people'*. It negates the work undertaken by allied health to educate and intervene to help create conditions for dients and carers to feel empowered to make changes. Similarly it sweeps under the carpet the ways in which the service culturally works to sometimes unnecessarily take power from people, reducing the scope for partnering with consumers and carers in a meaningful way.

- National and state-wide reforms/ standards/ repeated reviews/ staff feedback have highlighted the importance of the following Principles, which are not included in the MoC:
    - Delivery of Recovery Oriented care – as an internationally endorsed, evidence based and client driven this is a substantial omission
    - Respect for the individual's preference, strengths, values, beliefs and aspirations
    - Delivery of stepped care - instead clients are articulated within a binary of Acute and Non-Acute services, and not a spectrum of care.
    - Continuity of care
    - Integrated and co-ordinated care – within a team and across the MHS
    - Inclusion (ie. recognising and respecting uniqueness; protecting the rights of clients, carers and other support persons; recognising the possibility of clients having an unresolved trauma underlying their mental distress)
    - Least restrictive care
    - Person Centred Care
    - Earlier intervention

  'Recovery' has been identified in the Deloitte Report and earlier reviews as something staff often had differing understandings of, which needs to be articulated for clarity – especially to ensure a common interpretation across all disciplines.

- Unlike the current/outgoing MoC for Adult CMHS (and the MoC for Jamie Larcombe and Statewide Older Persons Mental Health MoC), none of the guiding principles and values in this MoC accompany a reference to how these principles will be achieved, what objectives they are expected to achieve, or how clients (and staff) will be any better off under this MoC.

  What the guiding principles are expected to achieve is fundamental to informing the development of the Service Plan, and staff being equipped to be involved in design and implementation in a constructive and clear way.

2. The contents of the Model:

- There is repeated reference throughout the MoC about CMHS clients being defined, (and the evidence base for services being sourced) by diagnostic category. Can SALHN please share a rationale for why the stated evidence base for CMHS will be reduced to RANZCP and the UK Nat Institute for Health Care Excellence? And why the net for collecting evidence based services is not being proposed as being wider within this MOC?
- What is the expectation for sourcing and evidence base for allied health interventions and roles in SALHN CMHS?
- A considerable evidence base exists about Recovery Oriented Services, Care Co-ordination and case management, specialist community rehabilitation, Assertive Care, Care Planning, Early Intervention, working with people who concurrently use drugs and alcohol. Why have these been omitted?
- Contemporary MHS reform agenda and the client evidence base confirms the need for clients to be subjected to less categorising and labelling, and CMH services to be prioritised based on identification of need.

- Similarly the contemporary evidence base for MHS is to recognise and intervene to address the many cultural, psychological, developmental, economical, legal, functional and social determinants and consequences of mental health conditions to support people's wellbeing. It is deeply concerning this is not acknowledged in the MoC, as these constitute much of the specialist roles and contributions of AH staff within CMHS.
- Members provided feedback to the Deloitte Report and previous reviews confirming a lack of definition about what the service Model is expected to deliver to dients who:
    - use drugs and alcohol
    - are aged between 16 – 25 years. There has been no previously endorsed MoC encompassing this age group (though it is acknowledged this is about to be reviewed in SALHN).
    - have a suspected or diagnosed personality disorder
    - have concurrent and comorbid issues (ie. physical, autism, intellectual disability, brain injury)
    - are homeless
    - are over 65 with chronic mental health conditions

      Members believe it is important for the MoC to address principles of care and overarching expectations for these groups, as the needs and pathways are not defined and are often contested within and between SALHN CMH.

3. Prior to moving to service planning, it would be beneficial for the PSA and CMH staff to be informed and to:

- see evidence of consumer consultation and their feedback on the MOC, before finalising their feedback
- receive confirmation feedback has been obtained by Office of the Chief Psychiatrist and the SA Mental Health Commissioner to ensure strategic alignment, and to see this feedback. This would help provide assurance.

Other than the above comments, PSA members support the proposed MoC. However, it is the PSA and members' position that the next steps around service planning must ensure that this MoC is resourced with adequate and appropriately skilled multi-disciplinary staff, and if this requires budget submissions to meet this requirement, then that is what must happen. The PSA and members are very aware that part of the failure of the last CMH Reform in 2011-2012 was that it was done with existing resources, and there has been minimal, if any, real increase in staffing for many years. Members support the proposed MoC and as such, believe it needs to be undertaken correctly from the beginning.

The PSA will await your consideration of, and response to, this feedback.

Should you wish to discuss this matter please contact PSA Organiser Rosie Ratcliff by phone on 8205 3284 or by email to rosie.ratcliff@cpsu.asn.au.

Yours sincerely

Nev Kitchin
General Secretary

cc Mr Michael Francese, Chief Workforce Officer, SALHN
My Wayne Dungey, Acting Manager, Industrial Relations, SALHN
Ms Dulcey Kayes, Co-Director, Mental Health Services, SALHN
Ms Laura Cooke-O'Connor, Acting Interim Allied Health Director, Metal Health Services, SALHN.