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SA Health

SALHN Doc no:

SOUTHERN ADELAIDE LOCAL HEALTH NETWORK
CLINICAL DIRECTOR MENTAL HEALTH SERVICES

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Mr Nev Kitchin
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Public Service Association
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By email: industrialassistants@cpsu.asn.au

Attention: Rosie Ratcliff, Organiser

Dear Mr Kitchin

SOUTHERN ADELAIDE LOCAL HEALTH NETWORK – PROPOSED ADULT COMMUNITY MENTAL HEALTH SERVICE PLAN V1.1 – RESPONSE TO CONSULTATION FEEDBACK

I write in reference to the ongoing consultative process underway in relation to the Southern Adelaide Local Health Network (SALHN) Community Mental Health reforms, including the Adult Community Mental Health (ACMH) Service Plan.

SALHN has considered the extensive feedback received from stakeholders about the ACMH Service Plan v1.1, and in consideration of this has revised the proposed Service Plan.

In consideration of the feedback from the Public Service Association (PSA) provided on 21 December 2018, please refer the attached table.

The proposed ACMH Service Plan v2.0, incorporating where appropriate feedback from all stakeholders, is expected to be released on the 5 March 2019 for a further two-week feedback period.

Your further feedback about this revised model is welcome and can be provided to Health.SALHNcmhsreform@sa.gov.au. On release of Service Plan v2.0 for consultation, presentations will be given to Staff, Consumer, Carer and Community groups in both the Marion and Noarlunga areas.

Feedback about the revised Service Plan v2.0 and Workforce Plan v2.0 is welcome and can be provided to Health.SALHNcmhsreform@sa.gov.au by close of business 19 of March 2019.

SALHN remains available to meet and discuss this matter and consultation about these reforms will continue as part of the SALHN Mental Health Consultative Forum, scheduled 1:1 meetings with Unions and other ad-hoc meetings as required.

Should you have any queries about this matter or to arrange a mutually convenient time to meet, please contact me on 8404 2604 or email Elisabete Moniz, Acting Executive Assistant to Professor Battersby at Elisabete.Moniz@sa.gov.au.

Yours sincerely

Malcolm,

Professor Malcolm Battersby
Clinical Director
Mental Health Services
Southern Adelaide Local Health Network

4 March 2019

Enc: Feedback Table

PSA Feedback	SALHN Response
Feedback	
1. Focus Group Summaries	Staff, including PSA representatives and members, were invited and provided with reasonable opportunity to participate in the Focus groups and as such were given the opportunity to contribute as part of this consultative process. The discussions and information shared as part of these focus groups has been considered as part of this proposal. It is not intended this information be provided, however the document 'Summary of Development of Service Plan' containing relevant information will be available.
2. Information and Evaluation from South Brisbane	Section 3 of the Service Plan provides information about Evidence Based Treatment and Care Planning and how SALHN have chosen to implement. Further, provided in the Service Plan is a comprehensive list of the Key Source References that have been considered as part of the establishment of this Service Plan.
3. Diagnostic Streams "a step too far" – seek implementation of Acute/ Non-Acute - subject to evaluation	Refer Section 3 of the Service Plan
4. Streams to be developed under current Teams	Refer the revised ACMH Service Plan Version 2. Each site - Marion and Noarlunga - will function with three Streams - Acute, Mood and Psychosis. The governance for the Acute and Mood streams will be combined into one Team led by a Head of Unit and a Team Manager. Similarly, the Psychosis Teams at each site, led by a Head of Unit and Team Manager. Each Team will comprise between two and three Workgroups.
Rationale for Diagnostic Streams 5. Comments/ Concerns/ queries	
• Evidence base regarding Diagnostic Streams	Refer previous response about rationale for Diagnostic Streams
• Evidence based therapeutic care and diagnostic streams	Refer Section 3 Evidence-Based Treatment and Care Planning for further information on how SALHN have chosen to implement this. See Service Plan and sub-sections named "Allocation" within each Stream for information on how consumers will be allocated to appropriately skilled staff.
• Access to therapy across teams for clients	There will be "fair and equitable" access to therapy for clients across teams. Consumer Groups' feedback has largely been positive and access to SALHN-provided services has not been raised as an issue.

• Training and specialist skills	Appropriate training will support the Service Plan, and a Training and Development Plan is under development.
• Streams names	The Service Plan clearly articulates the relevant Streams. In consultation with Consumer Groups these references are not opposed and have been in the main positively received. This has been openly discussed at the Staff Forums.
• How does SALHN MH differentiate services from NGOs/ PHNs - Headspace	Refer to the Glossary of Terms for Primary, Secondary (PHN sits across these) and Tertiary (SALHN MHS) within the Service Plan. Consumer Pathways and Operational Guidelines will be developed in consultation with stakeholders to support the Service Plan.
• Concern about clients being "labelled" • Fluctuations between streams - How will Clients receive care across streams? • Therapists working "across streams' • Non-acute stream rather than division based on diagnostic criteria	Consumer groups have not raised concerns with regard to diagnostic streams and feedback provided has been largely positive. As provided in the revised Service Plan it is intended to implement the proposal based on the three Streams. As has been discussed, implementation of this Service Plan will be subject to evaluation and review as well as continual improvement processes. Evidence-based treatment requires an acute provisional diagnosis or formulation of clinical impression upon assessment. This will be the significant contributing factor to which pathway the consumer will be aligned with. Once allocated to a Stream, consumers who require care from another Stream will, wherever possible, remain within their original Stream with access to other relevant support (including across Streams) when required, with the intention to minimise unnecessary disruption to continuity of care and care planning.
Other services 6. Other service plan comments/ queries	
• Evaluation of current services	The evidence for the need for change is an accumulation of service delivery recommendations, including the 14 recommendations from the Deloitte Report (as detailed in the Model of Care), the need for improved partnerships (see Mental Health: Exploring Collaborative Community Reform in South Australia) and critical incident review recommendations.

• Review and evaluation of other services - South Sydney	Refer above (Feedback • 2). Further to this, as has been communicated the Service Plan is a result of extensive review, analysis, engagement and consultation, including: • feedback received from consultation on the proposed Service Plan v1.0, November 2018 • staff and consumer focus groups • benchmarking and site visits with other jurisdictions • consideration of national and international evidence-based practice guidelines and best practice models • consideration of the 14 SA Health endorsed recommendations from the 2017 Deloitte Report, and key lessons learned from previous reviews of MH services • the recently developed SALHN ACMH Model of Care • relevant legislation and standards • current National and State mental health strategic directions. Further to the above in the revised ACMH Service Plan v1.0 a comprehensive list of the Key Source References that have been considered as part of the establishment of this Service Plan are listed in the Service Plan.
• Feedback regarding "operational" plan	Noted. The Service Plan has been revised to remove all unnecessary operational aspects. Consumer Pathways and Operational Guidelines will be developed in consultation with stakeholders to support the Service Plan.
• Rationale: Psychosis >20 years Mood >16 years	Noted. The entry age for all Streams is 16 years. This is reflected in the revised Service Plan v2.0

• Scope and role of Youth Team - Role being discussed with Team – needs to be discussed as part of this process - How is it different to what Headspace and PHN do?	The Youth Team remains out of scope for the CMH Reform. A separate review process continues to be undertaken to clarify their role within CMH and the interface with PHNs. The revised ACMH Service Plan v2.0 identifies that the target population is individuals aged 16 years and over. Youth MHS continue to provide a tertiary service to consumers aged 16-24, while headspace and other PHN providers will provide primary and secondary care.
• Management of consumers over > 65	Older Persons Mental Health Service remains out of scope for the CMH Reform. A separate review process is underway and a proposed Model of Care is currently being developed. The revised ACMH Service Plan v2.0 identifies that the target population is individuals aged 16 years and over.
• Concerns about availability of rooms and appropriateness of venue	A review of the required infrastructure and resources to support the Service Plan will be undertaken once the Service Plan is finalised.
Multidisciplinary Team Proposals and Concerns	
• Staffing profile resembles hospital wards - AHPs not being equal participants of team	AHP staff members are important members of the multidisciplinary team and will actively contribute to decision making and planning in relation to consumer's Treatment and Care Planning.
• OT members concerns - Separated from Teams - Less influence on decision making - Consumers needing OT falling through gaps	Noted. The Service Plan articulates the role and scope of the Discipline Specific Roles within Section 4 – Workforce, with the intention of increasing consumer access to discipline-specific skill sets across all streams and teams.
• OTs see benefit in remaining part of multi-disciplinary team taking on role of primary clinician with reduced caseload. - Case load to consist of complex comorbid conditions – brain	Noted and this has been amended in the revised in the ACMH Service Plan v2.0 OTs will predominately work within the Specialist and Discipline specific role and accessed across the Site, and may work as a Primary Clinician where appropriate, with multi-disciplinary Allied Health positions in the Primary Clinician space.

injury or cognitive disabilities – rehabilitation planning and interventions	The Senior Occupational Therapist is part of the Clinical Leadership Team and their (reduced) caseload will include consumers requiring complex care.
• Staff allocated to Teams and fragmentation (perceived) of Psychology, CRW and OT	Noted and this has been amended in the revised in the ACMH Service Plan v2.0 Refer Section 4: Systems of Care - Workforce. Strategic workforce planning will be an ongoing process. This will consider the future workforce needs required to embed, evolve and sustain service delivery over time.
• Role of Duty Worker	As the Duty Worker is not a position/role, this function will be detailed in the Operational Guidelines.
• Role of Senior AHPs - Primary Clinicians and Discipline Specific roles - Client load - Supervision - Port-folio work - Leadership meetings	Noted. Information about this is articulated in the Service Plan. All Senior AHP roles have been identified as members of the Clinical Leadership team. Refer Section 4: Systems of Care - Workforce. 'Each Team has a designated Clinical Lead for each discipline of the MDT to provide professional leadership to staff within their team.' The roles and responsibilities have been articulated under the Clinical Leads sub-section. It is proposed that the Clinical Leads may act in a Primary Clinician capacity for a number of complex consumers.
• Considerations for dedicated roles to link with NGOs – transition from IPRSS to NGOs/PHN - Deloitte Report (Transition Officers)	Information is provided in the Service Plan about existing positions for IBHSS Program Coordinator. Strategic workforce planning will be an ongoing process and will form part of the evaluation process for the Service Plan. This will consider the future workforce needs required to embed, evolve and sustain service delivery over time. As the Streams evolve, roles and functions, training and development needs, supervision and capability frameworks required to deliver high quality services will be modified in consultation with the Teams
• Team Managers - Functions/ roles/ locations	Noted. The Service Plan v2.0 has been amended in consideration of the feedback received, with Team Managers now being site based .
• Casual staff	Casual staff are utilised to fulfil ad-hoc needs and short term backfill of staff. Casual staff are allocated on an as needs basis and based on the relevant skills and qualifications of the relevant person. Casual staff will be utilised based on service and client needs. Further information about utilisation of casual staff may be reflected in the Operational Guidelines. It should be noted that at this point in time there are no planned changes to the use of casual pool staff across CMH.
• Mental Health Pharmacists	Noted. The Service Plan v2.0 has been amended in consideration of the feedback received. The role of Community Pharmacist has been incorporated into the Service Plan and is permanently funded.

• Assessments – physical and psychological assessments - Nurse - Social Worker - OT	Information about this is provided in the Service Plan - sub-section Assessment within each Stream. A Primary Clinician may be required to undertake a biopsychosocial assessment independently or with a team member from a complementary discipline. Access to more detailed or specialist assessments, such as the physical health assessment, will be provided as indicated.
• Management of referrals to generic team emails - CBIS	The revised Service Plan v2.0 addresses this. The wording has been changed to "Referrals from external services should be made using a standard referral form where possible". Further to this, the use of generic team email or otherwise will be clarified in the Operational Guidelines.
• Referrals – ED and Inpatient referrals	The revised ACMH Service Plan v2.0 addresses this. See references to Transfer of Care throughout the Service Plan. The terms 'acute' and 'inpatient' both refer to patients currently admitted to hospital. The term 'inpatient' is now used consistently throughout the Service Plan.
• Training and development - Links to SALHN Organisational Development and MH Educators	Refer previous comment about training and development. Funding has been approved for the development of an ongoing training, development and continuous improvement framework (through QUALITAS) for a period of 12 months.
Concerns about Staffing Profiles 8. Staffing Proposals	
• Concerns about FTE	This reform initiative and the underpinning Service Plan has been established in accordance with the Objective and Commitments of the *South Australian Modern Public Sector Enterprise Agreement: Salaried 2017* such that initiatives will continue to be introduced to improve the efficiency and effectiveness of the service and to enable the provision of quality services to government, the public and customers. The Service Plan and Workforce Structure have been developed with a view to ensure the agencies and its employees are dynamic, productive and responsive to the service needs of government, the public and customers. Notwithstanding, where additional resources have been identified as necessary this will be put in place.
• Administrative FTE	Further information about Administrative support is provided in the revised Service Plan v2.0. Additional administrative FTE has been proposed to support Heads of Unit and undertake other administrative functions. The function and allocation of administrative staff will be considered as part of the implementation of the Service Plan.
• Multi classification roles	Within Service Plan v2.0 all multi-classified roles remain multi-classified. Roles will be classified in

	accordance with service delivery needs and in accordance with any applicable underpinning industrial instrument. It should be noted that the FTE of multi-classified roles was underrepresented in Service Plan v1.0.
• Allocation of OT and Psychology AHPs – increase of FTE requested	Staff forums have outlined that, in terms of workforce modelling, there is not enough Psychology/OT FTE to be absorbed into core Primary Clinician numbers without potentially diluting/negatively impacting consumer access to the discipline-specific skill sets across all teams and streams. Therefore this FTE has been considered separately in order to broadly ensure consumer access across all teams/streams. The proposed Service Plan aims to optimise service delivery and improve access to discipline-specific skill-sets based on current FTE. Notwithstanding this, as outlined above, strategic workforce planning and development will be an ongoing process and will be part of the Service Plan evaluation. This will consider the future workforce needs required to embed, evolve and sustain service delivery over time.
• CRWs – working across SALHN MH and all streams - Additional FTE required - CRWs having notes countersigned	Noted. Information about this is articulated in the Service Plan and further clarification will be provided in the Operational Guidelines. The Service Plan articulates the workforce composition and structure and has been established in accordance with service delivery needs.
• Role of Duty Worker	Refer previous comment/ response.
• Team Leader roles/ allocation location	Refer previous comment/ response.
• Casual FTE required to be provided	Refer previous comment about Casual staff. Casuals are used on an ad-hoc and as needs basis and as a temporary/ short term backfilling arrangement. The Workforce composition and allocated FTE is illustrated within the Service Plan. At this point in time there are no planned changes to the use of casual pool staff across CMH.
• Medical Staff	Medical staff have been allocated in consideration of Service Delivery needs and in accordance with the underpinning Model of Care. The Service Plan v2.0 provides further information about the Medical Officer workforce and relevant FTE deemed required to support this proposal.

Managing Caseloads and the Workload Tool	The Review of Case and Client allocation was undertaken in response to the workload issues and dispute matters of both the PSA and the ANMF. Further to this the Caseload Review survey was not taken into consideration in the CMH Reform process. At a number of Staff Forums, the number of consumers that could potentially be discharged (as per the survey responses) was discussed, as a means to indicate a potential reduction in current caseload. The consumer numbers in the Service Plan continue to be based on the total number of open episodes within CBIS. The assessment of Case and Client allocation provided a thorough breakdown and analysis of work allocation and assisted in the better management of workloads. The Workload Escalation Pathway that has been developed has provided a clear escalation pathway should affected staff be so minded their case and workload is excessive and in their view unmanageable. Since the implementation of the Workload Escalation Pathway, there have been minimal incidents of affected staff escalating matters through the steps identified in the pathway. SALHN has exchanged correspondence about this issue and remains available should further discussion and consultation about the matter be required. The Caseload Review and the Workload Escalation Pathway were undertaken and established by experienced senior staff that are well versed in the management of CMH. This matter has been discussed in the FAQs (#2) that have been provided as part of this process.
Specific Feedback	
• p.14, 2nd paragraph: *"A key rationale for having dedicated acute community crisis intervention teams is to reduce acute mental health Emergency Department (ED) presentations, reduce avoidable hospital admissions, and improve quality of care...".* This is a hospital focus whereas CMH care is much more than hospital avoidance, and is acknowledged widely and internationally as the key service in mental health care.	The revised ACMH Service Plan v2.0 addresses this. Refer Section 5 – Acute Stream *The key rationale for having dedicated acute community crisis intervention teams is to provide rapid access to specialist care in the community to improve quality of care and clinical outcomes for consumers, reduce acute mental health ED presentations and reduce avoidable hospital admissions.*

• p.18: Rapid response only occurs with MH Triage Category One. All other categories should be responded to as non rapid response in the usual referral/triage processes as an acute stream	The revised ACMH Service Plan v2.0 addresses this. Refer Section 5 – Acute Stream *Crisis Response – rapid emergency assessment and crisis management within the Mental Health Triage categories of 2 (8 hours), 3 (24 hours) and 4 (72 hours). Comprehensive assessment, interventions aimed at symptom stabilisation, Treatment and Care Plan (up to two weeks), then Transfer of Care to most appropriate service*
• p 19: Rapid response is not solely an alternative to hospital admission, it is needed at many times to facilitate a hospital admission.	Noted and Agreed. Wording changed.
• p.21 and other streams: involvement of family and informal carers in assessment raises issues in terms of confidentiality and respecting the choice of the client to not always want those people privy to sensitive matters. This concern also applies to discharge/transfer of care. While it is known that family/carer support, where available, is critical, this should only occur where appropriate and under the guidance of the client in terms of how much involvement they wish those others to have in these discussions.	Noted and agreed. Significant changes made throughout the Service Plan and Workforce Structure to encompass the need for Family/Carer involvement. Refer Section 4: - Working with Family/Carers, including requirements for consumer consent where appropriate.
• p. 21 and other streams: "It is also essential to ensure that all consumers have a nominated GP". This can be extremely difficult when	Noted. Wording changed to *"it is desirable that all consumers have a nominated GP".*

the client does not have a regular GP or clinic, and arranging this when GPs or clinics may not have capacity or only accept clients when they have seen them themselves can be time consuming. The issue of clients choosing to not have a nominated GP must be considered as well.	
• p. 22 - "case formulation" and multiple uses of "case conference", "case management" and "caseload". Members believe this language needs to be changed. These are people not cases; and "case management" does not fit into a recovery model. These should be changed to terms such as "care conference", "client load" and so on.	Noted. Consumer group feedback has been largely positive and this has not been raised as an issue. Notwithstanding, the term 'case formulation' has been removed. The terms 'case management' and 'case load' remain in the Service Plan.
• p.24 and also under other streams – the requirement to obtain collateral medication history from at least three sources within 24 hours is unrealistic given not all clients have a regular GP, family or carer involvement and so on.	Noted. Changed to 'only be required from two sources'.
• p.27 and also under other streams – Transfer of Care or Discharge Meetings – to involved "service users" (should be re-worded as client), involved family, other MH services and in some cases other service providers. This will be extremely difficult to organise and	Consumer groups have not raised issues with the language and terminology used within the Service Plan and feedback has been largely positive. Notwithstanding this, and in consideration of the PSA feedback, wording has been changed to *"where appropriate, the consumer, family/carer and relevant external service providers should be invited to attend the meeting."*

needs to be considered in terms of expected length of time that the client will be cared for by MH services due to difficulties in arranging for GPs, other service providers to attend.	
• p. 29 – the criteria for the psychosis stream is 20 years and over - the care of younger people with early psychosis, if not by the SALHN CMH psychosis stream, needs to be stipulated clearly.	The Service Plan v2.0 addresses this. The entry age for all Streams is 16 years.
• p.30 and p.45 - “Triage daily” - triage occurs at multiple times throughout the day currently and members believe this still needs to happen.	Noted. However it is not intended that there will be a change to the term "Triage Daily"" in the Service Plan. The timing/frequency of daily triage opportunities will be addressed in the Operational Guidelines, as the needs will be different across the Streams and following the introduction of an emergency rapid response at each site.
• p. 41- there has been previous discussions regarding disability employment providers being co-located and also invited to meetings. In the past there were disability employment providers at psychosocial programs at Sunshine House and Trevor Parry Centre and there was much benefit in these linkages.	Noted. Refer Section 5 Psychosis Stream, Functional Rehabilitation and Skills Training. External service providers may be invited to attend Transfer of Care or Discharge meetings.
• p. 62 – as mentioned previously, OT and psychology being “across streams” will not be integrated and this concern is supported by statements such as participating at	Refer previous responses about OT and Psychology. Further refer to the Service Plan v2.0 in regard to the Stream/ Team Structure for all staff. Refer Section 5: Systems of Care - Workforce. Strategic workforce planning will be an ongoing process. This will consider the future workforce needs required to embed, evolve and sustain service delivery over time.

least three times per week in Acute team daily meetings, as well as needing to attend meetings in the mood stream. Much of their time will be spent in meetings if this is to be across two streams.	Also refer previous response re increasing consumer access to OT and Psychology skill-sets across all teams and streams.
11. Consumer feedback	Consumer feedback about the Service Plan has been largely positive and Consumer Groups are not opposed to the implementation of the Streams as provided in the Service Plan.
Resources to support the Service Plan and Workforce Structure	Noted. The Service Plan v2.0 has provided the proposed allocation of existing FTE to support implementation of the Community Reform. This reform initiative and the underpinning Service Plan has been established in accordance with the Objectives and Commitments of the *South Australian Modern Public Sector Enterprise Agreement: Salaried 2017* in that such that initiatives will continue to be introduced to improve the efficiency and effectiveness of the service and to enable the provision of quality services to government, the public and customers. The Service Plan and Workforce Plan has been developed with a view to ensure the agencies and its employees are dynamic, productive and responsive to the service needs of government, the public. The Service Plan v2.0 (as well as the information previously provided in Version 1.1) provides information about the proposed FTE to support service delivery.