PSA
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Professor Malcolm Battersby
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Dear Prof Battersby

Re: SALHN Mental Health (MH) – Adult Community Mental Health (CMH) Reform - proposed service plan and workforce profile – PSA feedback.

The Public Service Association (PSA) writes to provide feedback on behalf of PSA members in relation to the Adult CMH Reform proposed service plan and workforce profile, forwarded to the PSA on 9 November 2018. The PSA also refers to the Frequently Asked Questions (FAQs) documents released to staff on 5 December 2018 and 9 December 2018 (noting that while SALHN forwarded the first FAQ to unions, the second one was only forwarded to the PSA by members).

Feedback

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

1. The PSA and members note that no summaries have been provided from the Focus Groups and it is unclear how that work has informed the service plans. NALHN MH has released their Focus Group summaries to all staff and unions so all are very clear on the discussions, evidence and information that will underpin their service plan. The PSA and members seek that this be provided. Members involved in those groups believe there is a disconnect between what was discussed and anticipated to be in the service plans compared to what has actually been proposed.

2. Related to the above is the information regarding the other CMH teams visited as part of this work. While SALHN has chosen to use South Brisbane as the basis of the proposed service plan, the PSA requests that all information about all the teams visited is provided to the PSA and staff to assist in the understanding behind the proposals. In addition, it is noted that the South Brisbane models were developed three to four years ago (depending on the particular “stream”), therefore information about evaluations and amendments to the models since that time would be useful.

3. PSA members overwhelmingly believe that the move to diagnostic streams is “a step too far” at this point. Members believe that the first step should be a move to just Acute and Non-Acute streams at this point, with a review and evaluation of the functions/workforce requirements/client requirements later.

4. Further to the above, the majority of members believe that streams should be developed under the current teams – i.e. Carramar and Marion, and Outer South (acknowledging that Outer South will require additional resources to be able to “mirror” the Inner South two geographic teams). Marion team is

integrated and members report that on the whole, works well for both clients and the service. Carramar also has separate streams now. Another factor is that members describe having built relationships with clients, carers, General Practitioners (GPs), accommodation providers, and other services within those geographic areas, and believe that these should be maintained. By having one team only in Inner South would mean that some of those relationships with some of those clinicians would be lost as clinicians would be working over a whole geographical area rather than a specific catchment.

Rationale for Diagnostic Streams

5. Some of the thinking behind the above two points is based on members believing there is a lack of rationale for the diagnostic streams. Comments/concerns/queries include:

- What is the evidence base for deciding on diagnostic streams? This has also been raised under points 1 and 2 above.
- All clients need evidenced based therapeutic care - this does not have to happen in diagnostic streams. Allocation to clinicians should be based on person centred care needs and the skills required to meet those needs.
- Pathways to care need to be adapted according to a clients' symptomatology, functioning, developmental history and cognitive capacity
- Will there be fair and equitable access to therapy across the teams for clients - not based on diagnosis?
- What would training of specialist skills/ interventions look like? How will staff be trained in the interventions?
- Would staff be able to access training across the streams of interventions? If the diagnostic streams were implemented, this would be particularly useful if caring for clients with both mood and psychosis aspect of their illness.
- Will the streams would be named as per the document (e.g. 'mood stream' and 'psychosis stream') or more generic name?
- How does SALHN MH differentiate services from non-government organisations (NGOs)/ Primary Health Network (PHN)? Members have suggested a table would be useful – e.g. this is what PHN does/ Headspace does/ what SALHN MH does.
- There is concern as to how clients may feel with being "labelled" into a stream rather than being treated under person centred care principles based on symptoms, functioning and so on, rather than a diagnosis. This also raises issues for those clients who may not "fit easily" in one diagnostic stream or who have symptoms that fluctuate between the two "diagnostic criteria". Members wonder how will those clients receive the care or therapy they require if it is in another stream – do they "swap streams" or is that skilled therapist able to come out of their allocated stream to support that client? Members believe these issues would be alleviated by having a non-acute stream rather than division based on diagnostic criteria.

Other Services

6. Other service plan comments/queries:

- It is not clear how the current services have been evaluated. For example, there is much that works well, and other things that do not. How has the evaluation been done?
- Other services (such as in South Sydney) are moving to the same model as currently used by SALHN MH, specifically Inner South (as Outer South did not fully integrate). Has there been any review and evaluation of that service?
- While the PSA and members have been consistently advised by SALHN MH that this is not an operational plan, it comments on many operational aspects. This has been confusing for staff

when providing feedback, yet being told that “that is operational and will be considered as part of that process”. The document needs to be either operational or not.

- Psychosis stream accepts clients from 20 years of age, however acute and mood take people from 16 years. What is the rationale behind this difference?
- With the 16 year old acceptance age, where does the Youth Team fit? How can the Youth Team be ‘out of scope’ when the intersection with them is so important in all of this planning? Their role is being discussed with them but needs to be discussed as part of this process too. Another point related to this is clarity of their role – how is it different to what Headspace and PHN do?
- There are many existing consumers over the age of 65 years. Are they to be included in the new reform? The draft service plan states 16-65 years. Adult CMH work with people who are even 80 years old who cannot be transferred to older persons due to the client’s needs and the services offered by Older Persons Mental Health.
- While members welcome the focus on therapies, with the change to configuration and practice there is a serious concern regarding the availability of rooms, not just in terms of numbers but also appropriateness of venue.

Multidisciplinary Team Proposals and Concerns

7. Multidisciplinary Team proposals:

- Members believe that the proposed staffing profiles resemble hospital wards with Allied Health Practitioners (AHPs) providing input, not being ‘on the ground’ and being equal participants of the team.
- PSA Occupational Therapist (OT) members are very concerned about the risk of becoming separated from main teams with less influence on decision making and possibly consumers needing OT falling through the gaps.
- OTs see a benefit in remaining as part of the multi-disciplinary team taking on the role of primary clinician with a reduced caseload. They envisage the caseload would consist of those consumers with complex comorbid conditions, for example, brain injury or cognitive disabilities and needing rehabilitation planning and intervention.
- All staff need to belong to a team not be across teams - this is essential. In the current proposals Psychology, Community Rehabilitation Workers (CRWs) and OTs look like they are fragmented across teams. This will lead to isolation and loss of true multi-disciplinary care, with competing priorities causing issues in terms of planning and client care.
- It is noted that FAQ One stated the role of Duty Worker and how this will work is still to be determined. Proposals around this should have been provided as this role has a direct impact on both the functioning of the team and the proposed FTE noted below.
- This is also the case in terms of Senior AHP roles in terms of both the Primary Clinicians and the Discipline Specific roles, for example, holding a client load or not, supervision, portfolio work and leadership meetings. It is difficult for the PSA and members to comment on the effectiveness of proposals when they do not contain that information.
- Members also suggest there should be consideration given to dedicated roles to link with NGOs and assist with transition from IPRSS to NGOs/ PHN, improving flow and so on. This was suggested in the Deloitte Report (Transition Officers). Similar roles exist in Western Adult CMH which are providing much benefit to the teams and to clients.
- The proposed shared function of one Team Manager (TM) across all of SALHN MH Acute and one TM across all of SALHN MH Mood Stream is not supported. There must be one TM in each location and in each stream. The impact of travel is a serious concern as well as the number of direct reports. With face to face capacity of the TM being vital, teams will need to rearrange their meetings, reviews and so on to fit in with the TM’s timetable rather than those types of matters

being undertaken when it best fits the team and client care. It also shows little understanding of the TM's vital role in CMH.

- The function of casual staff has not been addressed. Will there be a SALHN MH or Inner South and Outer South casual pool? If this is the case, casuals will require "training" in all those areas. Or will there be casual pools for each stream? If this is the case, how will that work if there is more unexpected casual requirement in one stream in one location and their "allocated casual staff" have been already used and more are needed?
- Other MH services are investing in specific MH pharmacists to work within those areas - for example, Forensic MH. There is no mention of pharmacists at all in this document, despite references to medications, psycho-pharmacological education and so on.
- If assessments require both a physical assessment as well as a psychosocial assessment, then is it proposed that assessments will involve both a nurse and a Social Worker or OT?
- How will the "standard referral form to the generic team email" be managed and by whom? Also, how will this fit in with the current CBIS processes?
- It is noted that all referrals from ED and acute will be accepted. Why is this not the case for inpatients?
- The PSA and members welcome the commitment to training and support for at least the first 12 months from implementation. Will the external organisation also work closely with SALHN Organisational Development and MH educators so that the ongoing maintenance of this work, and assistance for new employees, can continue to the same standard?

Concerns about Staffing Proposals

8. Staffing proposals:

- A serious concern of the PSA and members is that the proposed workforce profile will mean this reform is "set up to fail". A common quote used by members is that SALHN MH have put "form before function" as it is clear that the proposed workforce profile has been developed by just using current FTE rather than a critical review of the skills and functions required and subsequent review of what FTE is required to implement the reform safely and appropriately.
- Although acknowledged by SALHN MH that administrative staff were not included in this document because it was clinically based, PSA members, including clinicians, felt that by not including these staff SALHN MH does not acknowledge their value and critical role in the operation of CMH teams. They should have been included in both the current and proposed workforce profiles, even if a note was added to reflect that there would be further consultation with administrative staff and the PSA as part of this process and that they would be included in the final service plan.
- There are roles noted as multiclassified. The PSA and members require a commitment that they will remain as such. There has been many instances of multi-classified roles becoming nursing specific. Given the critical need for skilled AHPs, this cannot occur as a result of this process.
- SALHN MH has openly advised at staff sessions that they do not have enough OTs to place in each team, therefore they have to be "shared" across Acute and Mood. It is the same for Psychology. The PSA and members believe that if this proposal goes ahead it must be done correctly from the beginning, not set up to fail, with implications such as those discussed as part of point seven. As such, it is critical that OT and Psychology FTE is increased to ensure safe and adequate FTE per team – not shared.
- CRWs play a critical role in CMH yet are also proposed to work across the whole of SALHN MH and across all streams. As with the OT issue, this will lead to isolation and loss of true multi-disciplinary care, with competing priorities causing issues in terms of planning and client care. It is vital that these roles be allocated to teams. Additional CRW FTE is required. In addition, in terms of counter-signing of notes, OPS3 staff have not had to have their case notes

countersigned for some years in agreement with various Team Leaders/Managers who considered it unnecessary due to their years of experience in mental health. CRWs find it extremely devaluing this is now being proposed.

- The role of Duty Worker must be clarified as mentioned in point seven as this will impact on FTE and client load numbers. If it is to be a dedicated role, this will impact on the number of FTE available for other functions. If it is to be a role shared among clinicians, it will impact in terms of the client load numbers and therefore on required FTE.
- As stated in point seven, there must be one TM in each location and in each stream. This cannot be achieved by reduction of other FTE – it must be additional.
- As also stated in point seven, casual FTE needs to be clarified and provided.
- There is a lot of reliance on medical staff in terms of their presence at a large range of meetings as well as every client seeing a psychiatrist. Has this been taken into account when determining the proposed medical FTE? Given that there are always competing priorities between clinical work (clinics, inpatient care, community care) and other requirements such as non-direct client care meetings, this needs to be considered.

Managing Caseloads and the Workload Tool

9. In relation to the proposed caseload numbers, this is welcomed as both a workload tool and a mechanism for ensuring a high standard of client care. However the actual development of this tool has raised concerns and queries for members:

- The PSA and members are seriously concerned that the brief questionnaire developed in the last few months to monitor workload has been used as a tool to develop these caseload numbers. This questionnaire is now being taken out of context and being used as a representation of the actual workload. The intention of this review was to have a very brief five minute discussion across CMH with all workers about their workload, and the questions were designed specifically to address the ANMF (SA Branch) requests as part of the resolution of their industrial action. The questionnaires are very brief and do not give a comprehensive picture of overall workload.
- PSA members understand that casual staff members' caseloads in Inner South were not addressed, yet as highlighted by the PSA previously, many casual are rostered and carry a client load. One of the casual staff members at the time of these reviews had 18 clients that they were supporting.
- The workload tool does not take into account many other factors such as portfolio work, covering of work due to unplanned leave, meetings, other day-to-day tasks and so on. There is nothing in the proposals to suggest those additional "non direct-care" functions were taken into account.
- The "tool" was used as a "snapshot" in time for a very specific purpose and by relying on this, the data is immediately flawed.
- The PSA and members believe the results need to be interpreted by someone who understands the workings of the CMH teams and have worked in them themselves.

Specific Feedback

10. Specific feedback about the document is as follows:

- 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.
- 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

assessment of care needs and either maintained by acute or onward referral to the non acute stream

- p 19: Rapid response is not solely an alternative to hospital admission, it is needed at many times to facilitate a hospital admission.
- 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.
- p. 21 and other streams: “It is also essential to ensure that all consumers have a nominated GP”. This can be extremely difficult when 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.
- 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.
- 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 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.
- p.30 and p.45 - “Triage daily” - triage occurs at multiple times throughout the day currently and members believe this still needs to happen.
- 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.
- 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 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.

11. The PSA and members have been advised that it is likely that feedback will be provided as a collated summary. However a summary of the client/carer feedback is also requested as has been provided by NALHN MH during their process.

The PSA and members reiterate that as per the comments in the PSA feedback to the MoC in July 2018, it is critical that the implementation of this reform is resourced in a considered manner with appropriately skilled multi-disciplinary staff. If this requires budget submissions to meet this requirement, then that is

what must happen. As also stated in the MoC feedback, the PSA and members are very aware that part of the failure of the last CMH Reform in 2011-2012 was that it was undertaken with existing resources. There has been minimal, if any, real increase in staffing for many years. Members believe that a reform of such magnitude and significance must be given every chance possible to succeed for their clients sake. Recent issues in Victoria have exposed a lack of adequate resourcing, with mental health experts, services, clinicians, unions, clients, families and carers all calling for an increase in resources to support reforms. This cannot happen here in South Australia again.

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

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Acting General Secretary

cc Mr David Morris, Chief Operating Officer, SALHN.
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