Community Mental Health report

A report from the Implementation Partner, Deloitte

13 July 2015
Executive summary

Mental Health (MH) is a part of the ‘clinical productivity improvement’ arm of Transforming Health. The broad objectives of the project were:

1. To assess and analyse the efficiency and effectiveness of community based mental health services with the aim to maximise mental health consumer flow and support.

2. To identify options to improve the capacity, flow and effectiveness of Community Mental Health (CMH) in metropolitan Adelaide Local Health Networks (LHNs).

The project included extensive stakeholder consultations, primary data collection and data analysis. The approach included:

- A census of the current mental health consumers being supported by specialist community mental health across Metropolitan Adelaide LHNs as of 21st March 2016. The census was developed by the Implementation Partner and completed on a total of 4,879 current mental health consumers which equated to 82% of all active community mental health (CMH) consumers at the time of the census.

- An online survey of 61 Consumers & Carers distributed through the state-wide mental health lived experience register.

- The development and completion of an online survey of community mental health staff – with 245 responses highlighting staff perspectives in relation to the current functioning of teams and suggestions for service improvements.

- Qualitative staff consultations at the team level, along with the facilitation of consultation forums with senior community mental health psychiatrists and Allied Health professionals working in community mental health.

The results of the data collection and analysis were presented at workshops with each of the three metropolitan Adelaide LHNs. The workshops sought to validate the key issues and findings and to develop future state solution ideas.

The NALHN future state workshop occurred on 6th July 2016, approximately 6 weeks after the current state workshop on 23rd May 2016. Based on the similarity of issues and suggested solutions at the SALHN and CALHN workshops, the NALHN future state workshop decided to focus in-depth on the issue of ‘Defining core business’ for specialist community mental health services. The NALHN workshop also examined the requirements and barriers regarding transfer of care to shared models or primary care models as part of a future stepped community model of care.

The issues and opportunities resulting from the workshops are highlighted below.

Issues and opportunities

Four broad areas of issues and opportunities were identified:

1. Managing Complexity of Consumers
2. Barriers to Transfer of care of consumers within the Community Mental Health Teams (CMHTs)
3. Clinics, Other Services and Access
4. How Community Mental Health services work as a team

1. Managing Consumer Complexity

An analysis of consumer complexity considered the extent to which the services of the CMHTs were appropriately tailored to the consumer population. The purpose of this was to assess if there were any changes needed in the target consumer cohort, the design of the CMHTs and the services which they provide.
The key issues identified in this area were:

- **Core business of CMHT is ill defined/focused** – in particular, who the services are for, how long can the services can be expected to be provided and the referral / transfer criteria into/out of CMHTs.
- **Access to services varies** – in particular, there are limited Drug and Alcohol (D&A) services which is seen as leading to increased demand within MH team
- **Variation in the extent of partnership with other services** – in particular, primary health, disability, housing and GPs.
- **Unclear and variable consumer journey** – in particular, across assessment, clinical outcomes, interventions, pathways for complex consumers, education for consumers and carers, family and carer interventions.
- **Skill mix and design of teams** – there is variation in the manner in which the integrated team model has been implemented as opposed to the streaming model. This means that teams have been designed differently and there are questions around whether current designs allow the best use of employees skills matched to consumer needs.

2. **Barriers to Transfer**

Barriers to transfer refer to any obstacles that hinder or prevent effective transfer of consumers from the CMHT to other services. A transfer may refer to a complete movement of the consumer to an external service or a partial transfer of the consumer under a shared care arrangement with the CMHT where required. Barriers may broadly be understood to be clinical or non-clinical in nature.

The key issues identified in this area were:

- **Risk aversion** – there is variation in management / decision making regarding when a consumer is safe to be transferred or when a case is considered ready to be closed. CMHTs feel that they need to accept all referrals due to the risk of rejecting referrals and an adverse event occurring afterwards. Likewise, there is an aversion to referring patients onto other services, (i.e. GPs and NGOs), with a perception by CMHTs that these services do not have an adequate level of skills or resources to manage these consumers. Within this there is varied availability and implementation of process and protocols.
- **Referral criteria** – the absence of clear referral criteria, which if available would support the management of referrals into the service and without is touted as a key reason for the unsustainable demand for CMH.
- **Appropriate support and services to transfer patients** – there is a perception that there are limited alternative care providers to support with transfer of CMH consumers. This includes NGO, youth services, longer term, D&A, tertiary and the care of clozapine consumers by approved GP prescribers.
- **Managing clients across the ranges of focus of care (FOC)** – the focus on acute response minimises time available for clients in the other FOC stages such as maintenance. The mismatch of clinical skills/care coordinator skills to consumer needs also appear to be a key issue. This is impacted by allocation decisions (i.e. which consumers are managed by which clinicians as well as care planning decisions such as who is involved in planning the care and discharge planning for the consumer).
- **Clinical guidelines / pathways** – It was highlighted that limited availability of clear clinical guidelines combined with ineffective clinical / caseload supervision has led to ineffective and passive care planning and interventions. A high percentage of maintenance consumers do not have clear transfer pathways and criteria for discharge and thus these consumers represent the group with the longest current and expected lengths of stay.
- **Managing episodic care** – the ease of re-entry and exit for consumers who experience episodic care needs was also an issue. CMHTs appear to “hold onto” consumers due to the difficulty of re-entry into the system and there is risk aversion among CMHT staff due to this difficulty.

3. **Clinics, other services and access**

This section examines areas of concern regarding the way CMHTs interact with external service providers.
The key issues identified in this area were:

- **Ineffective engagement with Primary Health Care** – Almost half of consumers that had a GP involved in their care were deemed to ineffectively engage with their GP suggesting better GP strategic relationships are needed to facilitate more effective initial assessments, care planning and transition of care.

- **NGO consumers require regular CMH review** – NGO contracts require a regular CMH review for consumers that are both receiving support from the CMHTs and additional NGO and private and/or public psychological therapy.

- **Large variation between LHNs regarding LAI administration** – The large variability between services in the model for administering long acting injections (LAIs) warrants a review into streamlining this service, with the potential to shift more consumers to GPs.

- **Lack of understanding of NGO capabilities** – General lack of understanding of the role, function and levels of NGO involvement suggests far more effective partnerships need to be formed with a clearer view on consumer service offerings and support structures between the Community teams and NGOs. For example, an OT-NGO partnership model would increase transfer to NGOs and overall flow due to increase in level of function and understanding when compensating strategies are actually needed.

### 4. How Community Mental Health works as a team

This section examines areas of concerns that were raised and observed in the way CMHT staff interact, cooperate and function together as a team.

The key issues identified in this area were:

- **Lack of common shared understanding regarding business processes** – There is a lack of clarity on, and variation in the interpretation of, the business rules, pathways and protocols into, through and out of CMHTs across a number of areas including the intake, assessment, treatment and referral processes.

- **Issues regarding streaming and specialisation of teams** – Staff often expressed the view that acute demand detracts from specialist skills and they felt like they were all becoming generalists, which they didn’t view to be a benefit to the consumers.

- **Ineffective monitoring and management of staff caseloads** – Staff often expressed there was ineffective caseload management / supervision.

- **Variation in team coordination and cohesion** – There were differences between teams, particularly in how they worked together across different FOC levels and different areas of the LHNs.

- **Trust and Team Morale Issues** – There were notable and concerning issues around trust and team morale in some, but not all teams.

- **Discrepancies between accountability and responsibility** – In particular, psychiatrists hold a lot of accountability but are not always involved in all relevant decisions on consumer care. Psychiatrists could be more involved in decisions of diagnosis and treatment plans.

- **Lack of clarity on employee roles and performance expectations** – There are poorly defined and understood role expectations and KPIs both at the employee and organisational level.

- **Lack of Effective Communication with consumers and carers** – There is a lack of effective communication with consumers and carers and involvement of consumers during the care planning & intervention phases of the consumer’s journey.

- **Lack of effective and efficient systems and infrastructure** – The inefficiency and ‘clunky’ nature of CBIS, with poorly defined processes and procedures around data governance and usage resulting in a large duplication of effort due to little consideration being given for historical data.

### Recommendations

In addition to the LHN level solutions developed through the workshops, the project team provide the following set of 14 recommendations to be considered to improve and redesign specialist community mental health services in South Australia. The recommendations include:

1. Define the core business of Specialist Community Mental Health in line with refined primary care models and commissioned services.
2. Refine the operating model for Specialist Community Mental Health with implementation of acute community and ongoing community streams.

3. Review and enhance the functioning of the Mental Health triage line.

4. Model staffing within the acute and ongoing community streams based on the likely daily/weekly referral patterns and transfers needed to primary care or to self-managed care.

5. Support the development of the rapid access assessment function in each community.

6. Identify the community based specialist skills and supports required for each phase of care and allow SCMH health professionals to practice at the top of their scope.

7. Implement mechanisms for review of consumers after a set number of sessions. Initiate early discussion with consumers and carers regarding progress and transfer to shared care.

8. Enhanced primary care and NGO interfaces and capacity development support.

9. Implement ‘Shared Care’ as the default option for all ongoing care consumers.

10. Consider trialling community transfer of care positions in each SCMH team to facilitate shared care and closure of maintenance consumers with long lengths of stay.

11. Streamline care plans and reduce the amount of time required for documentation.

12. Investigate refinements to CBIS functionality, including the ability for CBIS to be converted to a full electronic medical record system prior to the full implementation of ePAS.

13. Implement Community dashboards with targets and flow expectations.

14. Invest in the development of frontline team managers to understand flow, accountability and performance management.

Next Steps

It is to be noted that implementation of these recommendations will require a cross LHN approach in order to ensure consistency in the method and the outcomes. To facilitate this, it is suggested that small working groups of subject matter experts in community mental health be established with a view towards moving towards a pilot phase within the next 2 – 3 months.

In order to move towards implementing these recommendations, the LHN working groups need to identify the areas that are of immediate importance and identify the key solutions that can be quickly piloted. In preparing the implementation plan, LHNs need to take into account their constraints (financial, resourcing etc.)
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### Acronyms

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<th>Definition</th>
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<tr>
<td>LHN</td>
<td>Local Health Network</td>
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<td>CALHN</td>
<td>Central Adelaide Local Health Network</td>
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<td>CBIS</td>
<td>Community Based Information System</td>
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<td>CMH</td>
<td>Community Mental Health</td>
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<td>CMHT</td>
<td>Community Mental Health Team</td>
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<td>NALHN</td>
<td>Northern Adelaide Local Health Network</td>
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<td>SALHN</td>
<td>Southern Adelaide Local Health Network</td>
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<tr>
<td>DASSA</td>
<td>Drug &amp; Alcohol Services South Australia</td>
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<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<td>LOS</td>
<td>Length of Stay</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>SRF</td>
<td>Supported Residential Facilities</td>
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<td>FOC</td>
<td>Focus of Care</td>
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<td>HSP</td>
<td>Homelessness Support Program</td>
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<tr>
<td>IPRSS</td>
<td>Individual Psychosocial Rehabilitation Support Services</td>
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<tr>
<td>EPAS</td>
<td>Enterprise Patient Administration System</td>
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<tr>
<td>OASIS</td>
<td><em>This is not an acronym</em></td>
</tr>
<tr>
<td>STR</td>
<td>Support, Time &amp; Recovery</td>
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<tr>
<td>RDNS</td>
<td>Royal District Nursing Services</td>
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<td>SAPOL</td>
<td>South Australia Police</td>
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<td>NDIS</td>
<td>National Disability Insurance Scheme</td>
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<tr>
<td>PDSA</td>
<td>Plan Do Study Act</td>
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<td>PHN</td>
<td>Primary Health Network</td>
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1. Project background and purpose

1.1. Project purpose and objectives

Mental Health (MH) is part of the ‘clinical productivity improvement’ arm of Transforming Health. The broad objectives of the project were:

1. To assess and analyse the efficiency and effectiveness of community based mental health services with the aim to maximise mental health consumer flow and support
2. To identify options to improve the capacity, flow and effectiveness of Community Mental Health in the Metropolitan Adelaide Local Health Networks (LHNs).

The scope of this project included the three metropolitan LHNs; Central Adelaide Local Health Network (CALHN), Northern Adelaide Local Health Network (NALHN) and Southern Adelaide Local Health Network (SALHN).

Following consideration by SA Health and the Mental Health Portfolio cross-LHN Executive it was decided the Implementation Partner would only investigate adult community mental health services within metropolitan LHNs as part of the Community Mental Health Service Improvement project. The model of care, quality and safety of the Community Mental Health System was considered out of scope. Older persons and youth mental health services were out of scope, as were regional and rural mental health services. The review was, to be focused on state-funded services across the three LHNs.

The purpose of this report is to outline the main findings of the project across the three LHNs and present recommendations from the Implementation Partner’s (IP) perspective. Given the extensive nature of the project and the LHN specific approaches, this report provides a summary at a cross LHN level. More specific detail on each LHN can be found in the appendices. The individual LHNs have been provided these outputs via their Mental Health executive teams.

1.2. Project methodology

The project consisted of extensive stakeholder consultations, data collection and data analysis. The methodology is detailed below, with all information synthesised for the CMHTs’ current and future state forums. The outputs from these forums have formed the basis for this report.

1.2.1. Inputs into the CMHT forum

In order to develop the content for the CMHT forum and to identify the issues and opportunities in the CMHTs, a range of consultations were undertaken. Consultations and data collection methods included:

- A census of the needs of current consumers supported by CMH as of 21st March 2016
- An online Consumer & Carer survey
- An online survey of community mental health staff
- Qualitative staff consultations – through process mapping and qualitative interviews

1.2.1.1. CMH census

The information collected in CMH’s Community Based Information System (CBIS) was supplemented by a tailored, primary data collection census of all consumers with an open episode during the survey period.

The CBIS system is used to collect clinical case notes and other information about each mental health consumer. As there are limited enforced business rules and standards around the way data is entered.
into CBIS, there is a variation in the quality of consumer information recorded on CBIS, particularly with case notes.

The census initiative was launched after an analysis of the existing consumer data from CBIS in December and January raised concerns around the accuracy and relevance of data recorded regarding consumers. In addition, there was a need to determine additional information about the consumer including:

1. Consumer’s links to external service providers (e.g. primary healthcare, NGOs, Drug and Alcohol Services etc.) to understand options for shared care or transfer of care arrangements.
2. Consumer’s current and Estimated Remaining Duration of stay with the CMHT
3. Barriers for Sharing or Transferring Care for the Consumer

Between 21st March 2016 and 8th April 2016, a CMH consumer census was launched with the aim of collecting primary information about the current state of consumers in the metropolitan Adelaide community mental health system. The census addressed these issues by encouraging care coordinators to update their consumer’s existing records to ensure their relevance while also raising specific additional questions around points 1, 2 and 3 above.

In total, 4,879 census records were completed during the census period: 2,180 from CALHN, 1,133 from NALHN and 1,566 from SALHN. This was monitored daily to encourage staff and increase the final result of completed records. The final result equated to a response rate of 82% of all active consumers in the system. An active consumer is defined as a consumer who has received a face to face episode of care anytime in the last six months prior to 21st March 2016.

Census Methodology and Development

The final census contained 37 questions. The questions were of different formats, ranging from multiple choice answers, drop-down lists of options to questions with free text response options. In addition, there were consumers with more than one staff member identified as the main point of contact, resulting in multiple sets of responses. As several questions also had multiple possible responses (multiple choice), over 90 data values were collected against each consumer. These data values were supported by existing data about the consumer already collected from CBIS.

The census was developed through consultation with actual community mental health staff and team leaders, along with input from the SA Health Mental Health Strategy unit. Every CMHT in each of the three metro LHNs was provided an opportunity to comment on the census questionnaire during the development stage. An IP staff member was tasked with collating the feedback from various staff and incorporating changes between each revised version of the census questionnaire draft. Over 20 revisions were made to the draft of the questionnaire prior to the final version being published. A detailed log was maintained to track changes between the various versions of the draft.

The final census was deployed electronically within CBIS to ensure that the security of consumer data would be at the same level of rigour as current electronic consumer information stored within SA Health. Building the census into CBIS also increased the likelihood of completion as staff are familiar with the system, resulting in an easier learning curve.

The Mental Health Information Management and Performance Monitoring Unit at SA Health worked closely with the IP staff in a short time frame to build the census as a separate input form against each consumer’s profile. A report was also built within CBIS to allow the completion of the census to be tracked by team and care coordinator over the duration of the census period.

To support the rollout of the census, a guide and a glossary were produced as supporting documentation. The guide included screenshots of the electronic census on CBIS with illustrations to explain how care coordinators could access and complete the census. The glossary included a printable list of all the census questions, along with definitions of key terms and phrases to ensure that staff interpreted the questions consistently and a rationale column that explained the reason for including the question within the census. The rationale also explained how the information collected would be used in future analysis of the current state of the CMH system.

To initiate the census rollout, 7 training sessions were conducted across all three LHNs with care coordinators and other staff. During the training sessions, staffs were provided a refresher on the Focus of Care (FOC) classification system. In addition, any doubts regarding the census questions was clarified.
1.2.1.2. Consumer & Carer survey

The consumer and carer survey was developed as an additional initiative to capture the voice of the consumers and carers. A survey of consumers and carer survey was developed and conducted online between 17th May 2016 and 1st June 2016.

The 26 questions for the online survey was agreed to by the consumer and carer consultants at the state and LHN level and sent to consumers and carers on the consumer registrar. A total of 61 consumers and carers responded: 7 current consumers from CALHN, 6 current consumers from NALHN and 17 current consumers from SALHN. The remaining respondents were past consumers or carers.

The survey collected non-identifiable information. Where there were only a small number of responses from a cohort and it might have been possible to identify the consumers or carers, results were aggregated up to a larger group.

The survey asked questions across the following domains:

- Respondent details (consumer/carer), basic demographics, whether they are currently or recently involved in CMH, and teams they have received care from.
- Information on contacts with CMH i.e. frequency and duration.
- Consumers and carers views on the effectiveness of Community Mental Health in South Australia such as input into care, communication with CMHTs and the responsiveness of the service.
- Satisfaction with care, views on what makes a good CMH service and suggestions of what is done well and what could be improved on.

1.2.1.3. Staff survey

A survey of employees was fielded between 16th May and 31st May 2016. The purpose of the survey was to see to provide Community Mental Health staff with the opportunity to provide comment and ideas on how to improve Community Mental Health work practices in South Australia.

The survey was developed in consultation with metropolitan LHN mental health executive approved by the SA Health Mental Health project Executive Sponsor and state-wide Mental Health Industrial Liaison Forum. The online survey was sent to all community mental health employees via various methods, including email distribution lists held at each LHN.

A total of 245 employees responded: 104 from CALHN, 67 from NALHN and 68 from SALHN. 2 respondents from Country Health LHN responded but that LHN was not the focus of the survey or the analysis. The survey collected non-identifiable information. Where there were only a small number of responses from a cohort and it might have been possible to identify the employee, the results were aggregated up to a larger group.

The survey asked questions across the following domains:

- Information about the employee including team, discipline, qualifications, employment status, experience, age and gender.
- Time allocated to tasks and views on caseloads.
- Challenges that the staff face in their role and suggested improvements.
- Understanding of roles and accountability.
- Views on competency of themselves, teams and training requirements.
- Staff views on the effectiveness of Community Mental Health in South Australia such as leadership, consumer and carer involvement in care, communication with consumers and carers and the responsiveness of the service (i.e. meeting demand), skillset of the teams and the use of best practice methods and approaches.
- Job satisfaction.
- Key aspects CMHTs do well and aspects that they need to improve on.
1.2.1.4. Staff consultations

Both formalised and informal qualitative consultations were conducted across the three metropolitan LHNs. SALHN conducted an upward of 50 individual and small group semi-structured interviews over 3 weeks, led by their lead project officer. These more formalised consultations focused on asking employees detailed questions across the following domains:

- Current community mental health team structures (integration vs stream) and practices
- Work Tools
- Data systems
- Engaging other service providers
- Staffing profile
- Intervention
- Leadership
- Service improvement strategies

Thematic findings from stakeholder consultations at SALHN were recorded and used to inform the design of the SALHN forum. Qualitative issues were recorded through employee experience mapping workshops in NALHN and SALHN CMH Ts.

In addition, the Australian Nursing and Midwifery Federation (ANMF) (South Australia Branch) supported the secondment of a senior mental health nurse to the project. Staff consultations were conducted on a one-on-one basis or in small groups. Each CMHT had a minimum of one day’s consultation opportunity. The results of these cross discipline consultations will be reported to LHNs and SA Health separately to this report.

1.2.2. The CMHT forums

The forums were held on 31st May 2016 in CALHN, 6th June 2016 in SALHN and 23rd May 2016 (current state) and 6th July 2016 (future state) in NALNH. These forums formed an important part of the project. The forums were attended by between 60 to 80 employees from all major occupational categories within the CMHTs in each LHN. Consumers, carers and partner agencies also participated, but had a lower numbers of attendees involved as compared to CMHT employees.

The information presented in each workshop was a synthesis of data from the Community MH census, CBIS system data, experience mapping workshops and preliminary data from staff and consumer surveys. The forums were facilitated by both the Implementation Partner (IP) and each LHN CMH work stream leads and working group members.

The overarching objective of the forums was to:

1. Present the information and data collected through consultations about the current state of community mental health back to the audience and then validate these findings at the workshop.
2. Engage the CMHTs and mental health executive at each LHN in the design of the future state of the mental health system.

Within this, the purpose of the forum is to bring together key stakeholders from CMHTs to discuss findings from the pre-forum consultations and verify:

1. What is currently working well across CMHT operational processes
2. What is currently not working well across CMHT operational processes - issues and reasons
3. From the discussions against points 1 and 2, identify the areas for service improvement and potential solutions that could be tried in the future state. The barriers and enablers for these solutions were also identified.

The data underpinning the forums were designed into interactive stations and ‘whole of group’ feedback sessions. The discussions at the individual stations outlining key areas of interest were facilitated by LHN employees from the CMHTs.
The areas of interest were:

1. Consumer complexity
2. Demand and flow
3. Barriers to transfer
4. The mechanics of how we work (SALHN only) - this was rolled into section 6 below titled ‘How We Work as a Team’ in NALHN and CALHN
5. Clinics, Other Services & Access (NALHN current state workshop & CALHN) – this was captured in section 6 below titled ‘How We Work as a Team’ at SALHN
6. How We Work as a Team

Based on the similarity of issues and suggested solutions at the SALHN and CALHN workshops, the NALHN future state workshop decided to consider the issue of ‘Defining core business’ for specialist community mental health services in depth. The NALHN workshop also examined the requirements and barriers regarding transfer of care to shared models or primary care models as part of a future stepped community model of care.

The forums were tailored to local needs, based on the standardised dataset from the CMH census and surveys. The resulting forum packs vary in content to match these localisations. The outputs from the forum were documented and presented back to the LHNs to inform their future direction. The validated results are contained as appendices to this report.

1.2.3. Summarising and Synthesising the results from the forum

This report is based on the outputs generated from the CMHT forums. The views expressed by the CMHTs is summarised along with the views of the implementation partner (IP) regarding the areas for further investigation.

Recommendations for future directions are presented in Section 4.

1.3. Community Mental Health in Metropolitan Adelaide

The following sections provide the context in which metropolitan Community Mental Health services exist from a population, state and national perspective.

1.3.1. Prevalence and demographics

The purpose of this section is to explain the prevalence and demographics of CMH in South Australia. Across the three metropolitan LHNs, there are 7502 consumers with an open episode.
There are a slightly higher number of male consumers supported (55%) as opposed to female consumers (45%) in metropolitan Adelaide. Of the entire consumer population, 54% of the consumers are between the ages of 25 to 49, indicating a skew towards a slightly younger to middle aged population group for consumers.

Between the LHNs, CALHN has a slightly older population with 59% of its consumers between the ages of 30 to 54. NALHN and SALHN have a slightly younger population of consumers, with 54% of NALHN consumers between the ages of 25 to 49 and 61% of SALHN consumers between the ages of 20 to 49.

Across all three metro LHNs, the proportion of older episodes decreases over time, with 74% of episodes less than 3 years old as of 21st March 2016 (Figure 2):

- 48% of open episodes are less than 1 year old
- 17% between 1 to 2 years old
- 9% between 2 to 3 years old
However, there is a significant number of episodes (16%) older than five years, indicating that there are a large number of legacy consumers in the maintenance phase of care who have not been transferred.

Figure 3 below examines the prevalence of various categories of mental health conditions among consumers within the CMHTs.

Across all 3 metropolitan LHNs, the most prevalent provisional diagnosis amongst consumers is Schizophrenia (45%), followed by Unspecified mental disorder (27%) and Mood Affective disorder (11%). 60% of the consumers with Schizophrenia are in the Maintenance phase of care. This is 23% of all consumers within the CMHTs in all 3 LHNs. This segment of consumers constitutes the highest proportion of the active services within the CMHTs.

**Figure 3 - Proportion of all Metropolitan SAH Consumers by Provisional Diagnosis and FOC Stage**

<table>
<thead>
<tr>
<th>Provisional Diagnosis Group</th>
<th>Consumer Flow</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>25%</th>
<th>30%</th>
<th>35%</th>
<th>40%</th>
<th>45%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders</td>
<td>Assessment</td>
<td>10%</td>
<td>10%</td>
<td>23%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified mental disorder</td>
<td>Acute</td>
<td>3%</td>
<td>3%</td>
<td>11%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood affective disorders</td>
<td>Extended Intensive</td>
<td>5%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurotic, stress-related and somatoform disorders</td>
<td>Functional Gain</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour</td>
<td>Maintenance</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms signs involving emotional state</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural syndromes associated with psychological disturbances</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental and Behavioural Disorders due to psychoactive substance use</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CBIS, 21 March 2016

**1.3.2. Current system design**

Recent reviews of the SA community mental health system have highlighted several issues and recommendations regarding improving consumer flow through the public mental health system. LHNs and the Mental Health Strategy Unit of SA Health have been progressing a number of activities to assist with improving mental health consumer flow. However, the wait time for mental health consumers in the Emergency Department (ED) remains high and often exceeds 24 hours. Community mental health can, and does, play a significant role in preventing acute hospital admissions and Emergency Department presentations. This role can be further enhanced.

In 2007, the SA Social Inclusion Board submitted a report titled ‘Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007 – 2012’ which detailed 41 recommendations for improvement of MH services to the SA Government. 15 of the recommendations centred on creating a new model of Stepped Care for MH. In the stepped system, the MH service system is arranged as a tiered care system consisting of support across:

1. Secure care
2. Acute care
3. Intermediate care
4. Community rehabilitation centres (CRCs)
5. Supported accommodation

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Under the stepped care model, consumers should be able to transition through the system of care to receive the level of care that would best meet their needs and facilitate their recovery. The foundation of the stepped system is supporting people, wherever possible, to live in their own homes within the community. For the stepped model to work effectively, community mental health services were placed at the centre of the system of care.

However, currently, despite the implementation of stepped care, the mental health consumer journey often encounters blockages and transitioning through the stages of the system is often delayed. Despite improvements in average length of stay (ALOS) in acute wards there are times when mental health consumers wait for a bed within the ED for extended periods – often greater than 24 hours.

The mental health system of care and its associated consumer flow is complex. More than any other clinical stream, mental health patient flow relies on effective, efficient and appropriate access to psychosocial, non-acute and community based supports. Without an end to end approach to care within this system, the journey becomes blocked for the consumer. Carers, the NGO and the primary care sector are key partners in the mental health recovery journey. Better interfaces and engagement have potential to support a refined model of stepped care.

Approximately 5 years ago, as part of ongoing reform in the mental health system, CMHTs moved to an integrated model of care. The previous model of community care was described as ‘siloed’ with consumers having to wait long periods to be seen. Consumers also received variations in the level of support. This variation was dependant on their catchment of residence and resulted in delays and challenges in hand-offs between internal teams. Thorough integration, teams were brought together in modern facilities and the acute response, mobile assertive and ongoing care functions were merged into a single team. The aim of the integrated model was to provide a more generic, standardised approach to care with staff working across the acute response and ongoing care functions. The role of the Care coordinator was established as the backbone of the integrated care system.

There was strong opinion as to the success and challenges of the integrated care model leading to the impetus for the community mental health redesign project. It was felt that the competing demands to manage both acute response and ongoing support, sometimes within a single staff member’s shift, led to the perception that sub-optimal support may be provided. It was also felt that the competing demands led to poor staff morale. Acute demand from the centralised triage line referrals, Emergency Departments and from consumers transferring from the acute system back to community is prioritised, often trumping the need to support the ongoing care of longer term consumers. Consumers and carers could become ‘stuck’ in the system with extended episodes of care and it was found to be challenging to transfer these consumers back to a primary care level of support or to close their episodes of care.

1.3.3. Current national and state environment

The Community Mental Health redesign project comes during a period of national reform in relation to mental health services in primary care. The Commonwealth is a significant funder of mental health services provided in the community. Recent programs include:

- Personal Helpers and Mentors program
- Partners in Recovery
- Headspace youth centres
- Early psychosis programs
- Access to Allied Psychological Services (ATAPS) as part of the Better Outcomes in Mental Health Care program
- Support for day to day living in the community
- The Mental Health Nurse Incentive program
- Medicare Benefits Scheme items to develop, coordinate and support mental health care plans by GPs, private psychiatrists and psychologists

A number of these programs are provided through commissioned NGOs under Commonwealth Government contracts. The programs generally focused on psychosocial support to assist consumers to maintain community tenure but have evolved in recent years to have a greater capacity to deliver skilled clinical interventions through registered health professionals based in private and primary care settings. The Commonwealth also directly funded some public mental health services as part of the
National Partnership Agreement. These included the NALHN walk-in service and a number of community based crisis respite services. Funding for these services ceased on 30th June 2016.

In response to the National Mental Health Commission’s 2014 review of primary care level mental health services, the Commonwealth has funded Primary Health Networks as the commissioning agents for a broad range of primary care level mental health services. The idea is for the services to be more locally tailored and focused on the needs of the community. The reform program outlined a stepped care approach to community and primary care level mental health care thereby enabling consumers to access the right level of care at the right time. The Adelaide Metropolitan Primary Health Network has commissioned a consortium of NGO service providers to deliver psychosocial support with the announcement of the successful providers in July 2016.

In addition to the Commonwealth commissioned services, the South Australian government commissions NGOs to provide home based supports to through the Housing and Accommodation Support Program (HASP) and the Individual Psychosocial Rehabilitation Support Program (IPRSS) packages. The National Disability Insurance Scheme will become applicable to some mental health consumers with profound and persistent disability related to their mental health condition. However, this is estimated to only be a smaller proportion of the current consumers in SCMH or NGO support systems.

Finally, the South Australian government funds Specialist Adult Community Mental Health services. Specialist Adult Community Mental Health (SCMH) funding for metropolitan LHNs totalled $60,340,589 in 2014/15. The SCMH services operate across 20 teams in metropolitan Adelaide with approximately 462.5 FTE. There are 1875.41 funded FTE positions in all Adult mental health across all metropolitan LHNs. Thus, Adult SCMH FTE positions account for approximately 25% of all funded Adult FTE MH positions. The table below provides a breakdown of budgets and FTE positions by LHN. The clinical business rules define the operating processes for community mental health.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>CALHN</th>
<th>NALHN</th>
<th>SALHN</th>
<th>CHSALHN</th>
<th>TOTAL</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (16-64yrs ABS ERP 2014)</td>
<td>318,302</td>
<td>206,689</td>
<td>272,910</td>
<td>281,872</td>
<td>1,079,773</td>
<td>1,079,773</td>
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<tr>
<td>Population per 100,000</td>
<td>3.18</td>
<td>2.07</td>
<td>2.73</td>
<td>2.82</td>
<td>10.80</td>
<td>10.80</td>
</tr>
<tr>
<td>Budget</td>
<td>$28,676,730</td>
<td>$13,088,986</td>
<td>$18,574,873</td>
<td>$20,359,324</td>
<td>$80,699,913</td>
<td>$80,699,913</td>
</tr>
<tr>
<td>FTE (In scope)</td>
<td>208.00</td>
<td>116.10</td>
<td>138.41</td>
<td>201.84</td>
<td>664.35</td>
<td>664.35</td>
</tr>
<tr>
<td>% Medical FTEs</td>
<td>18%</td>
<td>14%</td>
<td>13%</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>% Nursing FTEs</td>
<td>41%</td>
<td>42%</td>
<td>41%</td>
<td>51%</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>% Allied Health</td>
<td>30%</td>
<td>33%</td>
<td>34%</td>
<td>23%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>% Admin/Support FTE</td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
<td>20%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>% Activity home own LHN</td>
<td>68%</td>
<td>78%</td>
<td>78%</td>
<td>92%</td>
<td>76%</td>
<td>76%</td>
</tr>
<tr>
<td>Activity (Contacts) per Clinical FTE</td>
<td>712</td>
<td>966</td>
<td>1085</td>
<td>263</td>
<td>711</td>
<td>711</td>
</tr>
<tr>
<td>Activity (Contacts) per Clinical FTE per day*</td>
<td>3.2</td>
<td>4.3</td>
<td>4.8</td>
<td>1.2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Funding per Activity (Contacts)</td>
<td>$219</td>
<td>$132</td>
<td>$141</td>
<td>$483</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td>Funding per Capita</td>
<td>$90.09</td>
<td>$63.33</td>
<td>$68.06</td>
<td>$72.23</td>
<td>$74.74</td>
<td>$74.74</td>
</tr>
<tr>
<td>Medical FTE per 100,000</td>
<td>11.6</td>
<td>7.8</td>
<td>6.4</td>
<td>4.2</td>
<td>7.62</td>
<td>7.62</td>
</tr>
<tr>
<td>Nurse FTE per 100,000</td>
<td>26.6</td>
<td>23.4</td>
<td>20.9</td>
<td>36.2</td>
<td>27.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Allied Health FTE per 100,000</td>
<td>19.7</td>
<td>18.5</td>
<td>17.2</td>
<td>16.5</td>
<td>18.0</td>
<td>18.0</td>
</tr>
<tr>
<td>Admin/Support FTE per 100,000</td>
<td>7.5</td>
<td>6.5</td>
<td>6.2</td>
<td>14.6</td>
<td>8.8</td>
<td>8.8</td>
</tr>
<tr>
<td>FTE per 100,000</td>
<td>65.35</td>
<td>56.17</td>
<td>50.72</td>
<td>71.6</td>
<td>61.5</td>
<td>61.5</td>
</tr>
</tbody>
</table>

Notes:
1. Data provided by SA Health Mental Health Strategy Unity
2. Clarity is required at an LHN level in relation to commissioned/funded versus non-commissioned/unfunded FTE
3. Data is 2014/15 and may have altered since this period
4. 225 working days (365 - 104 weekends - 10 Public holiday - 20 annual leave - 6 sick days)
5. CHSALHN - includes Community Intermediate Care Services
6. 2013/14 adult community mental health activity ‘contact’ data was determined using the ratio of the number of ‘individuals’ to ‘contacts’ for the financial year 2012/13 and applying this ratio to ‘individual’ activity data for the financial year 2013/14

Source: SA Health PBRAM Forecast, 2014 – 2015
1.4. Principles for Specialised Community Mental Health

The public specialist community mental service is one vital element within the mental health service system. Figure 4 below outlines the key elements of a mental health service system.

Figure 4: Key elements of a mental health service system

The majority of consumers have time limited disorders and can be referred back to their GPs after a period of weeks or months when their condition has improved. However, a substantial minority will remain with the team for ongoing treatment, care and monitoring for periods of months to several years.

People need ongoing specialist, community mental health care for:

- Severe and persistent mental disorders associated with significant disability, (e.g. schizophrenia and bipolar disorder).
- Longer term disorders of lesser severity but poor treatment adherence requiring proactive follow up.
- Significant risk of self-harm or harm to others (e.g. acute depression).
- Where the level of support exceeds primary care team offerings.
- Disorders requiring skilled or intensive treatments not available in primary care.
- Complex problems & multiagency requirements (e.g. under Mental Health Act).

The following key principles are proposed to guide and underpin community health service design:

1. Public/specialist community mental health as part of a stepped community system of care
2. Shared care should be the default – facilitating transitions
3. Most appropriate, least restrictive and least stigmatising care level of support
4. Provide easily accessible, timely, and appropriate assessment & therapeutic interventions
5. Time limited & early intervention whenever possible - aim for self-care or primary/non-clinical care
6. Recovery to consumers determined level is the goal
7. Consumer/carer centered, participatory & driven
8. Balance of ‘Acute and emergency care and treatment’ & ‘Mental Health Ongoing and Rehabilitation Support’
9. There should be capacity development support from the public mental health system to the broader private/primary care/NGO system in order to aid shared care and transfer of care but to primary health as part of the stepped community care system.
2. Findings from consultations

This chapter outlines findings from the surveys, census and consultations.

2.1. What are our Consumers & Carers saying

Consumer and carer perspectives were gathered through a cross LHN survey. Survey questions addressed their satisfaction with CMH services, the nature of the support provided and consumer and carer experience around transitioning out of CMH care. Insights were gained by collating and comparing results for each survey question where there was a valid response. Null responses have been ignored. Further information can be found in the survey data extract in the supplementary reference documents.

From the survey, we found almost half of consumers were ‘satisfied’ or ‘very satisfied’ with the overall service provided by the Community teams. However, over a third were ‘dissatisfied’ or ‘very dissatisfied’ with the overall service, as seen in Figure 5 below.

Figure 5: Consumer & carer satisfaction with the service provided by Community MH

![Chart showing consumer satisfaction levels](chart.png)

Source: CMH consumer survey

A similar result arose when asked of the ‘quality’ and ‘the way’ services are provided, although over half of consumers were dissatisfied with the ‘timeliness of access’ to the service. This raises questions around the CMHT’s responsiveness, caseload constraints and setting of expectations with consumers around how readily available and accessible services are as needed or demanded.

The survey revealed that consumers find that the community workers are highly respectful, non-judgemental and are good listeners. There was commentary around outstanding service from the front desk staff to clinicians. Several consumers have expressed that community workers don’t try to force their views and “suggest but do not ‘tell’ indicating that there is an inherent empathy for a consumer’s circumstances.

This view should be juxtaposed to numerous comments around dissatisfaction with the service based on arising themes of neglect and lack of communication by the CMHTs. The underlying reason cannot be inferred based on this data but if consumers are feeling they aren’t receiving the attention they need then this suggests more effective communication and interactions are required. Setting up-front the types and levels of support to be provided and managing the on-going consumer expectations around the responsibilities and service provided by the CMHTs must occur to mitigate these issues.
The survey indicates that over half of consumers feel that they sometimes or never receive services or activities from their community worker when they are needed. A similar proportion has indicated that they sometimes or never are given a choice about those services, as seen in the graph below (Figure 6). This insight raises concerns around communication, setting of expectations and the inclusion of consumers and carers in the development and design of their care plan and subsequent services they will receive. The graph below builds on this point as only half of respondents felt that they were at least usually included in the development of their care plan and in any decisions about their care.

Figure 6: Inclusion of consumers in decisions pertaining to care

"My Community MH worker gives me choices in relation to about the care I can receive. I am included in the development of my care plan and in any decisions about my care"

Source: CMH consumer survey

It is apparent in the survey comments that many of the respondents believe that the level of involvement of consumers in discussions around their care is not enough. The reasons given by some carers are that consumers may not be capable of advocating for themselves in those situations and having family, a carer or consumer representative present may achieve a better outcome. Furthermore, there was concern expressed around readily understanding what type of services are and are not available, which would limit constructive discussion and decision making around care planning.

Just as any successful organisation would regularly look inwards to assess the support and development of their staff, so too would they look outwards and consider the views of their customers. The graph below indicates that less than a quarter of consumers felt that they were mostly or always consulted about their progress or satisfaction with the service that they were provided.
Figure 7: Depiction of consumer view on Community elicitation of feedback on progress and service satisfaction

"My Community MH worker talks with me about my progress and seeks my feedback about whether or not I am happy with their support"

Source: CMH consumer survey

Seeking feedback on progress or satisfaction (Figure 7) supports the value and impact outcomes for the service. This should be part of the regular continuous improvement processes for CMH, allowing for rapid identification of what is working well and what is not working well. Often the simple act of business eliciting feedback can result in a more engaged customer or client base with better outcomes for both parties.

Figure 8: Breakdown of how engaged consumers felt regarding their readiness in stepping their care down to a lower support level

"My Community MH worker talked with me about moving to a lower level of support when I was ready"

Source: CMH consumer survey

Figure 8 above highlights a general gap in supporting consumers and their transitioning to lower acuity care settings or decreased level of support.
As part of the recovery approach, conversations should centre on empowering consumers and lowering the dependency or support level of the CMHT. This will be judged on a case by case basis, as it may not always be applicable to transition care out of the CMHT. Figure 9 below shows that 23% of consumers responding to this question deemed that transition is not applicable at this stage of their journey. However, the principle still applies that a recovery focused approach should always involve discussions on moving to a lower level of support when the consumer is ready.

Figure 9: Consumer perceived readiness to 'exit' Community care

"When I exited Community Mental Health support, I felt ready and supported to exit"

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>25%</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>23%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never occurs</td>
<td></td>
<td>26%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes occurs</td>
<td></td>
<td></td>
<td>26%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mostly occurs</td>
<td></td>
<td></td>
<td></td>
<td>15%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usually occurs</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always occurs</td>
<td>5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

Source: CMH consumer survey

Two thirds of those consumers that responded to the question in the graph above and also thought it would be applicable to transition care, felt that they were ‘never’ or only ‘sometimes’ ready and supported to exit community care. Transitioning consumers to primary care may be challenging for various reasons. For example, challenges include: consumer housing stability, accommodation supports, access to medication such as Clozapine and the chronicity of consumers’ conditions.

Improving the frequency of receiving and evaluating feedback along with helping consumers understand the part community plays in their journey of recovery could assist in improving the perceived ‘readiness’ of exiting community care. Further initiatives should be made by the CMHT in conjunction with their consumers to validate and better understand the root cause of this sentiment.

About 25% of consumers feel that upon exiting they are mostly advised of or connected to other community supports (Figure 10). It is not possible to determine the root cause of this based on this information. The general premise remains that helping consumers understand what entities exist to support them and what type of services they provide will aid the transition of care from the CMHTs whilst ensuring that effective recovery continues.
Figure 10: Community team linking in additional external community supports post transitioning

"When I exited Community Mental health support, I was advised of (connected with) other supports in the community to assist me"

Source: CMH census

Simply running through a brochure of external support services may not be enough as some consumers expressed difficulty in getting access to recommended support for simple reasons such as being ‘too anxious’ to call. This feedback suggests consumers would benefit from more effective transition planning, procedures and protocols that don’t just include transition support focus with the community but also include ward hand-over practices that require ‘ownership’ by external support partners to aid in this transition.

2.2. What did the CMH census tell us?

The census initiative was well received, with a high percentage of care coordinators engaging in the process. The census showed that only 79% of all metropolitan CMH consumers with an open episode had received a face to face appointment in the 6 months prior to 21st March 2016. Of these 82% had a census completed by their care coordinators. This completion differed between the three LHNs, with CALHN recording a 96% completion rate on the census for consumers with face to face activity in the last 6 months while NALHN recorded 59% and SALHN recorded 88% for the same measure.

The results showed that the majority of consumers within the metro LHN CMHTs are in the functional gain and maintenance phases with 34% and 33% respectively. 16% of consumers were deemed to be in the Extended Intensive Phase (See Figure 11 and Table 2).
It is notable that 32% of consumers in the acute focus of care have a LOS greater than 6 months. Given that the acute phase typically lasts less than 6 months, it is possible that there is still a lack of clarity among staff on how the focus of care system is used. Of all consumers, 6% are also in the maintenance phase and have a LOS greater than 5 years (Figure 12). A further ~ 4% of consumers are in the extended intensive and functional gain categories and have a LOS greater than 5 years.
Figure 12: Estimated remaining duration by current length of stay

Comparing the Current LOS of all consumers across all metro LHNs against their estimated remaining duration clearly shows a trend: Consumers with the highest LOS are also more likely to have a longer estimated remaining duration (see Figure 12). This can partly be attributed to an improved understanding of a consumer’s condition after a longer LOS, leading to a better ability to predict the estimated remaining duration. However, this also shows that as the LOS increases, the likelihood of the consumer’s estimated remaining duration being longer actually increases (thus impeding flow). For example, this is indicated by the fact that while only around 10% of consumers have a LOS greater than 5 years and are also in Maintenance, Extended Intensive or Functional Gain, the estimated remaining duration graph shows that 17% of consumers have a LOS greater than 2 years and are also expected to stay for at least another 2 years.

Figure 13: Proportion of consumers with drug and alcohol issues

63% of all metropolitan CMH consumers with a census had a Drug and Alcohol (D&A) issue, a medical co-morbidity or both (see Figure 13). Of the 42% of consumers with a Drug and Alcohol Issue, only 7% were involved with a Drug and Alcohol Agency. 66% of the consumers with a D&A
issue did not have any involvement with a Drug and Alcohol Agency, while 28% refused involvement with an agency.

Figure 14: Proportion of consumers with GP involved in their care

Source: CMH census

Of all consumers, 75% with a census result had a GP involved in their care (see Figure 14). However, only 65% of these consumers (48% of all consumers) effectively engaged with their GP. For the purposes of the census, effective engagement was defined as regular visits with the GP to discuss physical and mental health issues. The reduced engagement with GPs is a likely contributor to impeded flow and large caseloads.

2.3. What did we hear from the staff survey

A staff survey was used to supplement informal consultations and provide further insights into the views of employees of the CMHTs. As identified in the methodology, there were 245 responses (complete and incomplete) to the staff survey. 43% of the survey respondents were from CALHN, with 28% from NALHN and SALHN each. Nearly 60% of the respondents were between the ages of 40 and 59 (See Figure 15).

Figure 15: Staff survey by LHN and by age range

Source: CMH employee survey

Of all staff, 51% respondents were nurses, followed by social workers at 20%. Half of the survey respondents were on permanent full time contracts, with 27% of permanent part time contracts (Figure 16).
Figure 16: Responses by discipline and employment status

Source: CMH employee survey

Table 3 outlines some key characteristics of employees by experience in acute and community by specialisation.

Table 3: Key employee characteristics, of those who responded to the survey.

<table>
<thead>
<tr>
<th>Key employee characteristics</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experience in Acute/Inpatient Care</strong></td>
<td>26% of staff have over 10 years’ experience in Acute/Inpatient care, while 24% of staff have under 1 years’ experience. The majority of the experience lies with nursing staff, with social workers on average possessing less years of experience than nursing staff in acute/inpatient care.</td>
</tr>
<tr>
<td><strong>Experience in CMH</strong></td>
<td>Unlike Acute/Inpatient care, over 85% of staff surveyed had over 2 years of experience in Community Mental Health, with 39% possessing over 10 years and 22% possessing between 5 to 10 years’ experience.</td>
</tr>
</tbody>
</table>

Source: CMH employee survey

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Staff were asked to consider their own competence in particular interventions and therapies along with that of their team. The two figures in Table 4 contrast the views of employees on their own skills versus the skills of their team. Based on the self-competency Assessment, CBT, Psychodynamic, Family and Interpersonal Therapies are the main competencies where staff believe that they and their peers have skill deficiencies.

Table 4: Employees’ views on competency by skill area

<table>
<thead>
<tr>
<th>My competence</th>
<th>My team’s competence</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Psychodynamic therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Cognitive behaviour therapy for psychosis</td>
<td></td>
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<tr>
<td>Family therapy for psychosis</td>
<td></td>
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<tr>
<td>Interpersonal therapy</td>
<td></td>
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<tr>
<td>Supportive psychotherapy</td>
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<tr>
<td>Diabetic behaviour therapy</td>
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<tr>
<td>Drug and alcohol brief intervention</td>
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<tr>
<td>Motivational interviewing</td>
<td></td>
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<tr>
<td>Self management care planning</td>
<td></td>
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<tr>
<td>Brief CBT skills - collaborative goal setting</td>
<td></td>
</tr>
<tr>
<td>Brief CBT skills - collaborative problem definition</td>
<td></td>
</tr>
<tr>
<td>Brief CBT skills - problem solving</td>
<td></td>
</tr>
<tr>
<td>Brief CBT skills - cognitive restructuring</td>
<td></td>
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<tr>
<td>Brief CBT skills - exposure</td>
<td></td>
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<tr>
<td>Brief CBT skills - behavioral activation</td>
<td></td>
</tr>
<tr>
<td>Consumer psycho-education</td>
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<tr>
<td>Formulation</td>
<td></td>
</tr>
<tr>
<td>Drug and alcohol assessment</td>
<td></td>
</tr>
<tr>
<td>Risk assessment</td>
<td></td>
</tr>
<tr>
<td>Mental state assessment</td>
<td></td>
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<tr>
<td>Mental health history</td>
<td></td>
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<tr>
<td>Case coordination</td>
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</tbody>
</table>

Figure 16 presents the same data shown in Table 4. This figure highlights competency where employees see their skills differing from that of their peers. The purpose of this figure compared to those in Table 4 is to explicitly highlight these difference views of skill level. On average, across all competencies, 33% of staff believe that they are more competent than their peers, with 45% of staff believing that they are equally competent and 22% of staff believing that they are less competent than their peers.

Source: CMH employee survey
Figure 17: Employees’ views on competency by skill area relative to how they view themselves

Source: CMH employee survey

Qualitative consultations highlighted varying understanding of the roles and responsibilities across team members. Figure 18 explores the understanding on the care coordinator role. Only 65% of all staff surveyed believe that both they and their teams fully understand the role of the care coordinator. 38% of staff believe that they understand the role better than their teams, while 6% of staff believe that their teams understand the role better than them.

Figure 18: Employee’s views on themselves and their teams understanding the role of the care coordinator

Source: CMH Employee Survey

The staff survey also explored the issue of staff morale. 57% of staff across all three metropolitan LHNs either agreed or strongly agreed to the statement that they enjoyed coming to work. On average, the satisfaction level lies on “Agree” for the statement “I enjoy coming to work”. However, only 44% of staff at least agreed that their team enjoyed their work they do. On average, staffs believe
that the satisfaction level lies on “Neither Agree nor Disagree” for the statement “My team enjoys the work they do”. The discrepancy of 13% between these 2 figures highlights that more staff actually enjoy the work they do than their team members may realise.

However, an alternative interpretation can be made as well. 15% of staff at least disagreed or strongly disagreed that they enjoyed the work they do. However, peers only thought that 11% of staff disagreed that they enjoyed the work they do. Thus, in reality about 4% more staff do not enjoy coming to work than their peers may realise. However, this is a smaller discrepancy than the 13% on earlier, which bodes well for team morale in the community in general.

Figure 19 - Results of Staff Morale Questions

![Chart showing the results of staff morale questions.](image)

Source: CMH Employee Survey

An analysis of the top challenges faced by all metropolitan LHN staff reveals that **insufficient resourcing** was the largest category of issues experienced by staff, accounting for 40% of all issues raised. Staff comments highlighted the desire to provide a comprehensive and supportive service, but being hampered by a lack of specialised staffing. Comments also highlighted the high caseload per care coordinator. On average, based on an analysis of CBIS data, staff across all the metropolitan LHNs have 24 consumers each, but the range on this average is large, with some staff having as few as 3 consumers while others have as many as 45 or more. This is partly also driven by a failure to close completed episodes, with only 79% of consumers having had a face to face appointment in the last 6 months across all the metropolitan LHNs. Staff comments also stated that the allocation of resources was a key issue, with some teams being understaffed at particular times of the week in particular. Finally, staff mentioned that a lack of backfill as well as the challenge of having to juggle different responsibilities ranging from administrative work to training.

Figure 20 - Top Challenges faced by Staff

![Chart showing the top challenges faced by staff.](image)

Source: CMH Employee Survey

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Staff were also asked to list ideas that would make their outcomes better. As expected by examining the key issues raised, the majority of the ideas listed against solutions pertained to resourcing, with 27% of staff proposing various ways to increase backfill, specialised staff and overall resourcing. However, other solutions to address the resourcing issue included improved workload allocation (18% of proposed ideas) as well as improving role (12%) and core business clarity (6%). A number of proposed solutions also addressed improving infrastructure (20%), as well as the processes (14%) used to conduct business as usual within CMH.

**Figure 21 - Categories of Solutions Proposed by Staff**

![Solution Category Chart](chart.png)

Source: CMH Employee Survey
2.4. What did we hear at the workshops

The information provided at the workshops was divided amongst 5 categories, as seen in the table 4 below. The findings below outline key insights around the Community teams’ current state data and areas of focus to improve their service offering and consumer outcomes. Cross-LHN commonalities and LHN-specific points are called out separately for each workshop station. Appendix A, B and C present the data for CALHN, NALHN and SALHN respectively.

Table 5: Summary of workshops findings

<table>
<thead>
<tr>
<th>Station</th>
<th>Cross-LNH findings</th>
<th>NALHN Specific Insights</th>
<th>CALHN Specific Insights</th>
<th>SALHN Specific Insights</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Consumers in maintenance focus of care (FoC) comprise the largest portion of the consumer base in each LHN. They clients have the longest LOS, followed by Extended Intensive, and Functional Gain</td>
<td>Review of utility of CBIS data both how it’s being used and how it’s being entered - A consumer’s provisional diagnosis should not remain at F99 after assessment.</td>
<td>Engagement and utilisation of DASSA services lacking with a need to better understand the MoU</td>
<td>• 35% of clients have a Maintenance FoC, 29% Functional Gain and 29% Extended Intensive care. Only 5% of clients are Acute.</td>
</tr>
<tr>
<td><strong>Consumer Complexity</strong></td>
<td>• Staff consistently indicate that they are supporting consumers with growing complex needs / higher acuity needs, impacting their ability to manage more chronic consumers / consumers in Maintenance FoC</td>
<td>• Review required on root cause behind long waiting lists for internal services:</td>
<td></td>
<td></td>
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<tr>
<td>Are the services of the CMHTs were appropriately tailored to the consumer population?</td>
<td>• The CMHTs would benefit from a more consistent approach to engage and include the Primary Health setting and NGO providers into Community teams’ service offering</td>
<td>• OT</td>
<td>• A need was identified for better structured and more equitable staff development and training for each job group, with greater focus on interns and trainees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Almost half of consumers have a drug and alcohol (D&amp;A) issue, and most are not with a D&amp;A agency. Better training of staff required for managing D&amp;A conditions and behavioural mediation practices with more streamlined support by D&amp;A support services – internal &amp; external</td>
<td>• Cognitive Asses</td>
<td>• Lack of consistency and understanding around data governance and reporting practices</td>
<td></td>
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<tr>
<td></td>
<td>• The majority of consumers’ accommodation is supported by Housing SA, parents / carers or live independently</td>
<td>• Psychotherapy</td>
<td>• Large portion of consumers have accommodation supported by SRF – who are not MH trained and their response is to call an ambulance to ED</td>
<td></td>
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<tr>
<td></td>
<td>• Risk to staff identified with a significant portion of consumers with a propensity to violence being serviced in their dwellings, review on staff risk management practices required</td>
<td>• DBT Groups</td>
<td>• Of those consumers living with parent/carer, a quarter are unable to sustain stable housing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• General lack of integrating cultural specific considerations in service offering, particularly for Aboriginal and Torres Strait Islander consumer cohorts</td>
<td>• Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Demand &amp; Flow</strong></td>
<td>• Demand for services, as measured by accepted referrals, far exceed discharges or transfers out of the Community teams which is an unsustainable state if capacity is not growing rapidly enough to accommodate this pressure (over 50 more</td>
<td>• Staff training around managing and accommodating consumer expectations and preferences i.e. if they wish to stay and not transition to primary care</td>
<td>• Review rules around case management of IPRSS and understand level of support provided</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The longer consumers stay with the Community teams, the longer that the teams expect them</td>
<td></td>
<td>• Maintenance consumers represent the largest group by FoC in Inner South, in Outer South</td>
<td></td>
</tr>
</tbody>
</table>
### Station Cross-LNH findings

**Barriers to Transfer**

**What are the barriers to transferring consumers from CMH?**

- Most consumers serviced by the Community have identified barriers to transfer, with the largest proportion of these in the maintenance FoC
- Key barriers include ineffective engagement with other support services (NGOs, GPs), family / carer issues and lack of appropriate accommodation
- There is a general lack of consumer involvement in transfer process
- Discharge planning processes and procedures are inconsistent and are often initiated too late into the consumers episode and without the consumer and their family or carer present
- Lack of youth friendly / appropriate practices internally & externally (GPs)

### NALHN Specific Insights

1. **Are CMHTs currently able to appropriately meet consumer needs?**
   - referrals than discharges per day across the teams)
   - The pressure on the teams due to this demand will detract from both the ability to effectively service existing consumers and to keep up with new consumer demands, this is supported by survey findings whereby employees and consumers believe that services are only ‘sometimes’ provided in a timely fashion
   - Lack of clear referral criteria presents a challenge for triage teams to try and control demand, as explicit acceptance principles and criteria can be referenced
   - Poor use of strategic partnerships (NGOs, GPs, inpatient) to alleviate demand for Community services and provide lever to flex service if needed
   - Lack of a clear list of services, such as a prescriptive recovery based program, making it difficult to communicate and educate consumers on available services with flow-on effects of poor expectation setting on service / discharge periods (as appropriate)

2. **Barriers to Transfer**
   - Transfers of care processes are inconsistent and not streamlined within teams
   - Review support options for long LOS consumers - 20% of NALHN's consumers have an open episode without any face to face appointment in the last 6 months

### CALHN Specific Insights

1. **Are CMHTs currently able to appropriately meet consumer needs?**
   - to stay – potential lack of recovery focus and culture of hanging onto consumers for longer than necessary
   - Review in regards to demand management around service structure, as much variation across the time of day and day of week for all activity for community MH teams and variation for Clozapine and Depot clinics across the week (e.g. Tuesday)

2. **Barriers to Transfer**
   - Transfers of care processes are inconsistent and not streamlined within teams
   - Review support options for long LOS consumers - 20% of NALHN’s consumers have an open episode without any face to face appointment in the last 6 months

### SALHN Specific Insights

1. **Are CMHTs currently able to appropriately meet consumer needs?**
   - to NGO consumers i.e. HSP consumers
   - Detailed review into long LOS consumers in maintenance FoC is needed, as half of consumers staying greater than 12 months are expected to stay for another 2 years
   - Review in regards to higher acuity care needed, as although maintenance consumers are largest volume of caseload, half of direct time is spent with acute and extended intensive consumers

2. **Barriers to Transfer**
   - Transfers of care processes are inconsistent and not streamlined within teams
   - Review support options for long LOS consumers - 20% of NALHN’s consumers have an open episode without any face to face appointment in the last 6 months

### Functional Gain FoC represented the most consumers

- Demand pressures often undermine allocation practices, whereby any care-coordinator with spare capacity takes on the next consumer without stringent consideration towards their skillset or potential to streamline caseload given current casemix
### Cross-LNH findings

1. Almost half of consumers that had a GP involved in their care were deemed to ineffectively engage with their GP suggesting better GP strategic relationships are needed to facilitate more effective initial assessments, care planning and transition of care.
2. Review needed into consumers that are both receiving support from the Community teams and additional private and public psychological therapy.
3. Large variability in the service administering long acting injections warrants a review into streamlining this service, with the potential to shift more to GPs.
4. General lack of NGO involvement suggests far more effective partnerships need to be formed with a clearer view on consumer service offerings and support structures between the Community teams and NGOs, for example an OT-NGO partnership model would increase transfer to NGOs and overall flow due to increase in level of function and understanding when compensating strategies are actually needed.

### NALHN Specific Insights

- **How CMHTs can deliver services to the most appropriate group of consumers?**
  - Team work and cohesion is very important to the success of the team and that support, communication and empowerment by leadership is viewed as a key success factor to Community teams across all LNHs.
  - General theme around the inefficiency and ‘clunky’ nature of CBIS, with poorly defined processes and procedures around data governance and usage - large duplication of effort, little consideration for historical data.
  - Lack of understanding of business rules and processes and the availability of documented rules, processes and work instructions vary between staff.
  - Employees across each LHN often express that they find it difficult to quarantine time for particular aspects of ‘value-add’.

- **Mechanics and supports for how we work**
  - Significant portion of staff time dedicated to non-value adding services such as chasing information for referrals, referrals where the consumer does not wish to engage or time spent transporting patients between services.
  - Review into back office support function to understand capacity to support care coordinators with administration activities.

### CALHN Specific Insights

- **How We Work as a Team**
  - Review is required into staffing practices and more closely aligning it to service offering i.e. when is backfilling appropriate, when and how should short term contractors be utilised.

- **How We Work as a Team**
  - Cultural and capability related issues around staff operating in generalist roles.
  - Growing acute demand from highly strained ED and inpatient setting will detract from the care coordinators ability to structure their day to day work around the majority of their consumers in more stable maintenance or

- **NALHN Specific Insights**
  - Lack of adequate training and support for GPs limits their willingness to engage with Community teams.
  - Lack of sophisticated partnerships with GPs to support clozapine administration, which would lessen the burden on Community teams for this service.

- **NALHN Specific Insights**
  - Acceptance of medication does not markedly differ with GP involvement, suggesting Community efforts in assisting with consumer acceptance of medication could be managed by GPs.
  - Review into consumers with high proportion of direct service time on telephone calls – better define appropriateness of calling to lower demand on face to face care and identify transition options for long LOS consumers with predominantly telephone interaction.

- **NALHN Specific Insights**
  - Governance mechanisms and structure could be better defined in terms of who is responsible for consumers care, who holds the risk, who holds the control and who is accountable, and how can the teams remain flexible around these principles.

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1. SALHN ran a separate station called **Mechanics & supports for how we work** that had an added focus on the support mechanism for CMHTs, primarily information systems and business processes, in addition to governance and leadership.
### How We Work as a Team (continued)

<table>
<thead>
<tr>
<th>Station</th>
<th>Cross-LNH findings</th>
<th>NALHN Specific Insights</th>
<th>CALHN Specific Insights</th>
<th>SALHN Specific Insights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>work, such as therapy</strong></td>
<td></td>
<td></td>
<td>functional gain FoC</td>
<td></td>
</tr>
<tr>
<td>• Integrated team structure lacks sophistication around how to best instigate effective collaboration, knowledge sharing and staff upskilling, due to a lack of clearly defined mechanisms and responsibilities around team / group purpose, function and structure</td>
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<tr>
<td>• Poorly defined and understood KPIs undermines Community wide collaboration and efficiency, due to a limited view of what needs to be done, how should it be done and what success will be measured by</td>
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</table>

The workshops produced further insights around key current state issues and potential opportunities for improvement; the participants were also asked to prioritise some of these opportunities. These issues and opportunities were weighed up against the broader body of information that has been gathered and has been factored into later sections of this document. Please refer to appendices A, B and C for a detailed list of workshop output, including key issues and prioritised opportunities, as outlined by participants in their various breakout groups on the day.
2.5. Discipline specific qualitative findings

Further initiatives were pursued to capture the voice of specific disciplines. This took the form of a cross-LHN senior medical forum, a cross-LHN Allied Health forum and investigative consultations by a representative of the Australian Nursing and Midwifery Federation (ANMF). These initiatives sought to enrich and to some extent validate the findings from the other primary consultation initiatives outlined in earlier sections above. Key points from the Allied Health and senior medical forums are listed in the sections below. The findings from their seconded staff member will be provided separately by the ANMF to SA Health and LHNs.

2.5.1. Allied health forum

Allied Health Staff mentioned the following reasons to explain why they are passionate about working in CMH:

- Keen to provide mental health services to individuals who would otherwise be unable to access the service (marginalised individuals).
- Keen to understand how mental health problems can present within the home environment.
- Enjoy working collaboratively with the consumer and their families to enable recovery.
- Enjoy working in partnership with other stakeholders.

Key findings and discussion points arising from this forum are as follows:

- The integrated model results in a loss of specialised skills - staff with a skill and focus on acute or ongoing care are not differentiated anymore. In addition, being seen as a general worker affected staff morale as it limited their ability to work at the top of their scope.
- There are a number of issues with CBIS, including the lack of availability of specific reports to certain staff roles.
- There is confusion and a lack of clarity surrounding the scope and core business of a CMHT.
- As the focus of CMHTs is shifting to hospital avoidance, consumers needing long term care are being marginalised.
- The role of the care coordinator and clinical coordinator is also unclear - the clinical coordinator has to undertake a wide range of activities, including patient transport.
- CMHTs are being tasked with filling the gaps in external services (Primary health, NGOs etc. rather than being a specialist service).
- The resources are not distributed in a way that enables us to offer specialised services to all the consumers who need it.
- The context of core business cannot be defined the same way for every team as the catchment areas demographics and presenting conditions are very different.
- There were concerns among staff that senior staff are disconnected from the pain of the employee at the coal face.

2.5.2. Senior Medical Forum

Key findings and discussion points arising from this forum are as follows:

- **Integrated team model** has worked well to reduce red tape by removing siloed teams or business units. The model has also allowed for broader dissemination of skills and knowledge that would otherwise remain with a select few staff. However, what has transpired is an increasingly deskillled and demotivated workforce that lacks consistent opportunity to practice discipline specific skillsets. A review is required to understand how to overcome this disenfranchised staff workforce by more clearly outlining the core business of MH and the subsequent function and structure of the teams to support this service offering.
- A clearly articulated and mandated **clinical governance model** will have a measurable effect on staff at the grass roots level, who are expressing a heightened **dissatisfaction around clinical supervision**, particularly when comparing against other professionals who feel more empowered through increased medical oversight. Having clear clinical role descriptions and outcomes along with broader cross disciplinary governance in place would provide a robust starting platform for change.
- The MH model that is being refined needs to recognise its own failings, successes and evolution from when MH was once an out-reach from a large hospital, moving towards
gradual migration of the locus of control in the community, yet this mechanism is not well defined or established.

- Increasing demands for MH services in the Community has the model unintentionally moving towards an assessment focused service and less on therapeutic intervention. A review is required to understand how the integration model drives this practice, with suggestions to be put forward on **potential changes to streamline the integration model, involving teams with an acute care and longer term care bias**. Streamlining integration will change Community MH culture with staff that sees itself towards longer term care as opposed to service to only keep people out of ED.

- The participants in the medical forum suggested a tendency to de-medicalise those people needing longer term care and pass them onto NGOs – some participants suggested these services are often not well supported or equipped to meet these consumers' complex needs and thereby suggest a more sophisticated strategic partnership based solution.

- **Workforce mobility and flexibility** remains paramount to scaling against fluctuating demands of the consumer base. Staffing and rostering needs review to overcome 7 day workforce challenges, as currently nursing is the primary profession that runs a consistent 7 day roster.

- The constraints on funding and inherent disinclination of disciplines to work with or ‘own’ consumers with drug and alcohol comorbidities have made this cohort extremely problematic across the system. There was a suggested need to **instigate cross-discipline collaboration to manage the drug and alcohol problem** that is blocking EDs and detracting from effective care delivery in the community.

- **Enhance, but balance, risk management practices**, through initiatives such as using the Safe Tool – if there’s a clinical indication to manage risk then do it, but risk should be stratified.

- Review required into **processes centred around technology / system usage**, such as the use of CBIS, OASIS. Systemic issues around the use of technology and the actual value it adds to the CMH service offering.

- There is a **lack of data-driven and evidence-based decision making**, which is both at an operational and medical level – The service has operationally been developed on anecdote with poor data reporting integrated into usual work flows and practices.
3. Issues and opportunities from LHN consultation

The following section outlines the key areas investigated, the key issues and opportunities identified and the significant barriers and enablers. At the time of writing, findings from the NALHN forum was not available, therefore issues and opportunities presented in this section are based on the CALHN and SALHN forums. Appendices A, B and C present the data for CALHN, NALHN and SALHN respectively.

For each area of investigation below, the key messages and issues identified are examined. The issues that were identified across the areas of investigation often appeared in a number of areas, therefore opportunities against these issues were also repeated in a number of stations.

3.1. Key areas of investigation

The stakeholder consultations and data analysis investigated five areas of the functioning of CMHTs at each LHN. Six areas are listed below as the LHNs approached analysis how their teams work and clinics and other services different, see below. These areas of interests are:

1. Consumer complexity
2. Demand and flow
3. Barriers to transfer
4. The mechanics of how we work (SALHN only) - this was rolled into How We Work as a Team in NALHN and CALHN
5. Clinics, Other Services & Access (NALHN &CALHN) – this was captured in How We Work as a Team at SALHN
6. How We Work as a Team

Sections 3.1.1 to 3.1.6 present the consolidated view of the issues that arose during the project. These sections further refine the findings presented in Table 5.

3.1.1. Consumer complexity

Our analysis of consumer complexity asked if the services of the CMHTs were appropriately tailored to the consumer population. The purpose of this was to assess if there were any changes needed in the target consumer cohort, the design of the CMHTs and the services which they provide.

Key Issues

The key issues identified in this area were:

1. **Core business of CMHT is ill defined/focused:**
   - In particular, it is not clear who the services are for and the referral / transfer criteria into/out of the CMHTs.
2. **Access to services:**
   - There are limited D&A services and this is seen as leading to increased demand within MH team.
   - In addition to limited access to services, there is an issue around skill development, defined resources and pathway development for D&A services.
   - There is limited access to sustainable housing matching consumer needs.
3. **There is variation in partnership with other services (e.g. primary health, disability, housing and GPs):**
   - There is a view that GPs are uncomfortable in managing MH consumers.
   - It is difficult to get transfers to ED.
   - There is a need for NGOs packages, as well as development of education, pathways, matching packages with needs.
   - There is the view that there is limited suitable of sustainable housing matched to consumer needs.
4. **Consumer journey is unclear and variable across phases:**
   - For Official Use Only-I3-A3
- Assessment, clinical outcomes, interventions, pathways for complex consumers, education for consumers and carers, family and carer interventions.

5. **Skill mix and design of teams:**
   - There is not a definition of or standardised way of implementing integration (versus streaming). This means that teams have been designed differently and there are questions around whether current designs allow the best use of an employee’s skills while being matched to a consumer’s needs.
   - There is uncertainty on what is need in a multidisciplinary team, in particular the roles and responsibilities, whether new roles required, as well as training and development required.
   - Incorrect skills mix to match consumer needs (e.g. youth).

### 3.1.2. Demand and flow

Our analysis of demand and flow asked if CMHTs are currently able to appropriately meet consumer needs. The purpose of this was to determine how CMHTs could work smarter to achieve the most benefit to the appropriate consumer groups who need community mental health services.

The key issues identified in this area were:

1. **Risk aversion**
   - There is variation in management / decision making. CMHTs feel that they need to accept all referrals due to the risk of rejecting referrals and an adverse event occurring. Likewise, there is an aversion to referring patients onto other services, i.e. GPs and NGOs, where CMHTs observe that they do not have an adequate level of skills or resources to manage these patients. Within this there are varied availability and implementation of process and protocols.

2. **Referral criteria**
   - Confounding the point above on risk aversion is the absence of clear referral criteria, which, if available would support the management of referrals into the service and without is touted as a key reason for the unsustainable demand for CMHTs.

3. **Appropriate support and services to transfer patients**
   - There are limited alternative care providers to support with transfer of CMH consumers. This includes NGO, youth services, longer term, D&A, tertiary and the care of clozapine consumers.

4. **Managing clients across the ranges of focus of care (FOC)**
   - It was strongly highlighted that the focus on acute response minimises time available for clients with other FOC such as maintenance clients.
   - The mismatch of clinical skills care coordinator skills to consumer needs also appear to be a key issue. This is impacted by allocation decisions (i.e. what consumers are managed by which clinician) as well as care planning decisions (i.e. who is involved in planning the care and discharge planning for the consumer).

5. **Clinical guidelines / pathways**
   - The limited documentation of clear clinical guidelines was identified in as a significant issue impacting the flow of patients through CMHTs.
   - It was highlighted that limited availability of clear clinical guidelines combined with ineffective clinical / caseload supervision has led to ineffective and passive care planning and interventions.
   - In particular, the high percentage of maintenance consumers do not have clear transfer pathways and criteria for discharge, thus represent the group with the longest current and expected length of stay.

6. **Managing episodic care**
   - The ease of re-entry and exit for consumer who experience episodic care needs were also an issue. CMHTs appear to “hold onto” consumers due to the difficulty of re-entry into the system and risk aversion due to this difficulty.

### 3.1.3. Barriers to transfer

Barriers to transfer relates to the barriers to transferring consumers from CMH. Areas of focus include:

1. How do CMHTs overcome these barriers

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2. How can CMHTs better coordinate and cooperate (‘join-up’) services and
3. How do CMHTs ensure consumers are transferred safely to ensure best timely care?

The key issues identified in this area were:

1. There is not clearly defined scope of core business, therefore it is difficult to determine when a consumer no longer meets this need/level of care (i.e. has recovered) and should be transition from the service.
2. There is limited consumer and carer/family involvement in discharge planning and clinical reviews.
3. There appear to be poor discharge planning practices, in particular not involving the consumer and carers in discharge planning as much as would be appropriate and planning re-entry if required.
4. Access to and confidence in other services who support discharge is an issue for CMHTs
   - There is a view that GPs are uncomfortable in managing MH consumers
   - There is also the view that there is a lack of MH expertise outside the CMHT, limited suitable support services and insufficient of clozapine services to consumer needs. Both these issues result in CMHTs feeling they are unable to discharge consumers.
5. The structure of the team does not always facilitate the appropriate levels of support based on consumers need and the appropriate caseloads. A key implication of this is an impact on the limited time team members have to work with consumer and appropriately discharge plan.

3.1.4. The mechanics of how we work

The focus on examining the mechanics of how CMHTs work was designed to understand how to streamline processes and improve the systems which support CMHTs. This station focuses on data and system requirements/tools, balance time between administration, assessment and care delivery and the business rules and processes.

The key issues identified in this area were:

1. The resourcing profile of teams, particularly in terms of administration, transport, clinical time and the ability to quarantine time for tasks is not always optimal. This includes issues around backfill and managing team work functions
2. The technology available to CMHTs does not support CMHTs as well as it could and at times add burden to workloads and dictates some work practices (i.e. when and how assessments are completed) which might not always be the most clinically appropriate approach.
3. The data systems are not always supporting efficiency of practice/priorities of core business
4. There is duplication of effort, multiple systems of paper and electronic versions of records
5. There is limited access to resources to support services/care e.g. rooms for consultation, assessment and therapy

3.1.5. Clinics, Other Services & Access

The focus of the area was to identify where clinical management (e.g. for long acting injections or clozapine) through the clinic system impeded flow and transfer to primary care.

The key issues identified in this area were:

1. There is limited support from primary health and other mental health services
2. There is a lack of transfer of care criteria
3. There is a lack of clear business rules around aged care, aged related needs and over 65s
4. There are ineffective engagement with NGOs in terms of relationships, model, demand and transfer of care
5. There are poor service model around medication clinics including the criteria to receive a service, access to services, consumer preferences and medication requirements.
3.1.6. How We Work as a Team

The ‘How we work as a team’ section of the workshops focused on addressing how CMHTs can deliver services to the most appropriate group of consumers. Of particular focus was governance, best use of skills, team work and leadership. In our consultations we heard from the employees that there is a dedication and focus on providing consumers and carers the best available care. However, there are also a number of issues identified.

The key issues identified in this area were:

1. There is a lack of clarity on pathways and protocols into, through and out of CMHTS across a number of areas including the intake, assessment, treatment and referral processes.
2. There is a number of issues around the streaming and specialisation of teams.
   - In SALHN, there was also significant variation in how this occurs across team, with outer south organised notably different to inner south.
   - Staff often expressed the view that acute demand detracts from specialist skills and the felt like they were all becoming generalists, which they didn’t view to be a benefit to patients.
   - Staff often expressed there was ineffective caseload management / supervision
3. Similarly, there is variation in the cohesion and coordination across teams, particularly in how they would together across FOC levels and different areas of the LHNs.
4. There a notable and concerning issues around trust and team morale in some, but not all teams.
5. There are discrepancies between clinical accountability and operational responsibility. In particular psychiatrists hold a lot of accountability however are not always involved in all relevant decisions on consumer care. They could be more involved in decisions of diagnosis and treatment plans.
6. Further, there are poorly defined and understood role expectations and KPIs both at the employee and organisational level.
7. There is a lack of effective communication with consumers and carers and involvement of consumers care planning & intervention.

3.2. Opportunities

A number of opportunities for improvement were identified through the consultations and workshops. These opportunities identified often fit into more than one of these areas. These are summarised into 5 broad areas for improvement, including:

1. Strategy
2. Service model improvements
3. Team structure, engagement & culture
4. Supports for CMHTs
5. Model of care

The subsequent section (Section 4) provides a summary of the prioritised recommendations from the Implementation Partner’s perspective, based on all of the key findings and identified opportunities.

3.2.1. Strategy

The purpose and role of the CMHT is not clear internally. Clarifying CMHT’s role and how it will support the broader strategic initiatives of MH and the wider health and community support system will help focus staff, assist in guiding choices regarding resource commitment or investment and elevate CMHT’s profile to directorates & other external service MH providers.

Strategy covers two key areas, clarifying and defining the role and design of CMHTs and improving the whole of system integration and coordination. The purpose of this is to ensure that there is a consistent and clear understanding of the core business of CMHTs and how they sit in the broader system.

Clarify and define the role and design CMHTs was a suggested opportunity through all workshops and consultations. Defining core business within current resource base was seen as a priority and should include:
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- Defining and understanding core consumer base
- Defining CMHT core services including the role of youth services
- Defining how CMHTs are designed and delivered
- Defining services which are out of scope i.e. aged care needs – including process and tools of identifying out of scope needs.

It was suggested to improve whole of system integration and coordination by:

- Developing information to assist system navigation for services (including CMHTs, NGOs, inpatient, D&A, primary care agencies, GPs, Aboriginal services and youth services), consumers and carers
- Developing processes for working in partnerships with other organisations, including service coordination, liaison, memorandums of understanding (MoUs) and information sharing
- Reviewing the consistency of service provision across areas, including MH triage

3.2.2. Service model improvements

The service model of CMHTs was seen by workshop participants as not being well documented, understood and consistently applied by CMHTs. This was despite having detailed clinical business rules.

Opportunities were identified across a number of service model elements. The key areas identified through this project are 1) process improvement, 2) discharge and transition planning and 3) enhanced consumer experience. The participants felt these opportunities would provide streamlining of service provision, appropriate standardisation and provide succinct and well document processes, pathways and procedures for CMHTs to follow.

Service model and process improvement opportunities were suggested to include:

- Refine/further develop core business rules
- Developing clear referral pathways into and out of CMHTs, including entry and exit criteria matched with level of service provided
- Developing standards for assessment and clinical reviews
- Developing a clearly defined consumer flow/pathways through CMHTs including expected services, reviews and timeframes
- Developing a state-wide clozapine clinic/clinical pathway
- Developing standards for information collected i.e. at assessment and reviews (including KPIs),
- Ensuring consistency and standardisation in working behaviours and care delivery
- Develop clear referral pathways into and out of CMHTs, including entry and exit criteria matched with level of service provided
- Develop standards for assessment and reviews
- Develop a clearly defined consumer flow/pathways through CMHTs including expected services, reviews and timeframes
- Develop a state-wide clozapine clinic/clinical pathway
- Develop standards for information collected i.e. at assessment and reviews (including KPIs),
- Ensure consistency and standardisation in working behaviours and care delivery
- Ensure that processes support/improve continuity of care for consumers

Improving discharge and transition planning opportunities were suggested to include:

- Developing/refining for discharge planning, commencing on entry into the service, including standards, processes and expectations for discharge planning. Particularly review discharge planning for long-term maintenance patients.
- Reviewing and refining how and when patients can re-enter the service if needed and coping/self-management plans on exit. This includes developing business rules, information and processes around this
- Investigating the potential for a dedicated discharge resource
- Working with interrelated services, particularly GP and NGOs to improve access to these services and the confidence of these providers to support successful discharge
- Develop guidelines for transfer of care onto GPs, private practices, PHNs
- Enhance leadership support and targets for transfer of care
• Investigate a way for GPs to alert CMHTs for instances such as missed appointments for short term follow ups

**Enhancing the consumer experience** was suggested to be able to be improved by:

• Reviewing and enhancing the involvement in consumers and carers/families in service provision, particularly
  o Care planning
  o Critical reviews
  o Discharge and transition planning
• Investigating barriers and develop solutions to improve the efficiency of care provided to clients

### 3.2.3. Team structure, engagement and culture

A number of opportunities to address significant issues in the functioning of the CMHTs were suggested. Improvements to the culture of the teams and morale was seen as a high priority need. The purpose is to enhance the cohesion and functioning of the CMHTs to benefit both employees and consumers.

Enhance the functioning within CMHTs was suggested could be achieved by:

• Improve the information sharing, communication and transparency across CMHTs, including reviewing aspects such as morning team meetings and forums for sharing information
• Work on enhancing strong leadership skills, practices and expectations across CMHTs
• Investigate the potential for more time for clinical discussion
• Enhance the support and supervision roles for employees, particularly when dealing with acute related issues and risk management
• Produce welcome/on-boarding packs for new employees which sets out processes, roles, responsibilities and expectations upfront.
• Work with CMHTs to build/enhance a culture of mutual respect, trust and support.

Opportunities for review of team and individual caseload and skills mix (with enhancement of capabilities where required) were identified in the workshops and consultation. It was suggested these could be achieved by:

• Development of a skills Matrix for team
• Reviewing process around staffing allocation decisions (staff skills / interests view readily available) and processes for regular casemix reviews.
• Review options to enhance education and training for staff across skill areas such as drug and alcohol, the recovery model
• Investigate specialist teams/role like whether forensic clients care managed by forensic team, youth specific teams where they are not currently available,
• Investigate and develop separate roles / functions of services provided by Mental Health specialists, support and admin roles
  o Examine the potential for lived experience representatives in all major CMHTs
  o Indigenous and Culturally and linguistically diverse (CALD) team members.
• Review options for quarantining time for specialist skills (i.e. allied health), team functions and for different consumer groups (i.e. acute versus maintenance)

### 3.2.4. Improving supports for CMHTs

CMHTs identified a number of issues around information technology, data as well as resources both physical and personnel. CMHTs identified a number of opportunities to improve supports to their teams. Supports for CMHTs covers three key areas, 1) technology System Improvement, 2) review internal supports for CMHTs and 3) Review external supports for CMHTs. The purpose of this is to support the CMHTs operate as efficiently and effectively as possible.
Technology System Improvement opportunities included:

- Commence a project to improve CBIS i.e. to make it more intuitive, quick links, improve functionality, flags for new information or when something needs to be reviewed. For example transfer of care options / fields in CBIS as not-user friendly leading to process breakdown
- Investigate the potential for laptops to access CBIS/EPAS clinical databases, mobile access and/or tablets
- Review need to have a printed/paper file
- Investigate the potential for a new IT system/significant modifications to the current system
- Investigate the potential for electronic systems that enable upload of documents
- Investigate the potential for access to EPAS/OASIS for Inner South teams

The suggestion to review internal supports for CMHTs, included:

- Renegotiate how and for what administration support is provided
- Undertake a project to source consultation rooms during high demand periods
- Investigate the potential for transport support works for transport
- Investigate options to backfill
- Investigate the potential for home based care

The suggestion to review external supports for CMHTs suggestion included:

- Investigate the potential for support workers for community rehabilitation workers (STR workers)
- Review NGO support workers / packages available and develop process for making this information readily available
- Review housing options to provide a range of support levels

3.2.5. Model of care improvements

While out of scope of this first phase of CMHTs improvement, a number of opportunities have been identified around the model of care in CMHTs. Opportunities identified around the model of care were to:

- Develop pathways that clearly define the short and long-term client pathways
- Investigate the need for prescriptive recovery program / clinical pathway (6 sessions, 4 visits etc.)
- Develop upfront recovery based discharge plan
- Investigate training that transfers to clinical practice with appropriate clinical supervision (development of good clinical practice)
4. Recommendations

This section provides a consolidated list of recommendations stemming from the extensive consultations and analysis conducted. They include the priority opportunities and solutions from the LHN level workshops. A set of 15 recommendations has been developed based on our extensive consultations and data analysis.

1. Define the core business of Specialist Community Mental Health in line with refined primary care models and commissioned services.
2. Refine the operating model for Specialist Community Mental Health with implementation of acute community and ongoing community streams.
3. Revise the current community mental health business rules to provide a more flexible framework and define those items that need standardisation.
4. Review and enhance the functioning of the Mental Health triage process.
5. Model staffing in acute and ongoing community streams based on the likely daily/weekly referral patterns and the transfers needed back to primary care or self-management.
6. Support the development of rapid access assessment function in each community team, including for stable SAAS transfers.
7. Identify the community based specialist skills and support required for each phase of care and allow SCMH health professionals to practice at ‘top of scope’.
8. Implement mechanisms for review of consumers after a set number of sessions with early discussion with consumers and carers of progress and transfer to shared care.
9. Enhanced primary care and NGO interfaces and capacity development support.
10. Implement ‘Shared Care’ as default for all ongoing care consumers.
11. Consider the trialling of community transfer of care positions in each SCMH team to facilitate shared care and closure of long stay maintenance consumers.
12. Streamline care plans and reduce the amount of time required for documentation.
13. Investigate refinements to CBIS functionality, including the ability for CBIS to be converted to a full electronic medical record prior to full implementation of ePAS.
15. Invest in the development of frontline team managers to understand flow, accountability and performance management.

4.1. Detailed recommendations

The following section provides more detail on each of these recommendations.

Recommendation 1: Define the core business of Specialist Community Mental Health in line with refined primary care models and commissioned services

An overarching issue identified from the current and future state workshops across all three metropolitan LHNs was the need to define the core business of their community mental health service – and to consider themselves ‘Specialist’ Community Mental Health (SCMH) as part of the stepped community care system. NALHN have commenced this work as part of their future state workshop. On the basis of the core principles of SCMH (UK Department of Health, 2002)² Core business should include clear expectations and communication of:

- An expectation of the consumer remaining in contact with a General Practitioner as part of shared care.

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The ability for brief and comprehensive assessments be completed in a timely and streamlined manner to support primary care and NGOs.

The minimum standards and types of therapeutic and other interventions a consumer and/or carer can expect as part of a course of care.

The liaison and capacity development role SCMH should provide to NGOs, primary care and private mental health providers.

**Recommendation 2: Refine the operating model for Specialist Community Mental Health with implementation of acute community and ongoing community streams**

Staff consulted through workshops, employee survey and qualitative team level consultations all supported refining the integrated team approach to work/case allocation. While most could identify benefits of team enhancement and skills transfer with the integrated team approach the majority of staff and management supported refining the model. The skills sets and focus of interventions for people in acute phase of care was seen as quite different from those in functional gain or maintenance phases. The generic nature of the team and the need to rapidly respond to acute referrals impacted on the level of support provided to consumers requiring ongoing care as well as consumer flow through SCMH. Planned transfers back to primary care, self-management or NGOs did not get the focus required for effective transitions and discharges.

LHNs should conduct scenario modelling and trial the implementation of two streams of SCMH – ‘acute community’ and ‘ongoing community’. Those consumers requiring a crisis response or intensive, episodic, community support should be managed by acute community SCMH stream. If a consumer’s focus of care is aimed at functional gain or maintenance this should be managed by the ongoing stream. This approach has similarities to the streaming of patients in Emergency Departments. Streaming of ED patients to ‘likely to admit’ and ‘likely to discharge’ streams has been proven to improve ED flow and care.

The focus and skills for the two streams will differ and expected length of care episode will vary. The acute community stream needs to be able to respond quickly to crisis and to flex the level of support provided based on risk and need – up to twice daily occasions of service. The care plan and interventions may vary between the two streams with shorter care planning processes in acute community and a series of brief (but intensive) evidence based interventions should be available to reduce risk and the duration of the acute/intensive phase of care.

The acute community team should be skilled and staff to provide Community in-reach to acute with prioritisation based on need and relative risk for the timeliness and structure of post-acute specialist community mental health support. The implementation of these reforms should occur in a manner which does not ‘lock’ staff to a particular stream (as occurred previously pre-integration) but allows flexible scaling up and down of staff within streams based on demand and skill sets.

**Recommendation 3: Revise the current community mental health business rules to provide a more flexible framework and define those items that need standardisation**

The clinical business rules should be replaced. They are implemented differently in each team and do not provide the flexibility to respond to individual consumer needs. There is a need to provide some standardisation in order for consumers and carers to receive similar access and standards of care. However, a refined SCMH framework may provide greater flexibility and the ability for innovation to meet local catchment needs.

**Recommendation 4: Review and enhance the functioning of the Mental Health triage line**

The mental health centralised triage line has been operating since around 2007. It was implemented at a time of centralised bed management across the mental health system. The triage line has not been formally reviewed during the period but has had some adjustment to referral timeframes and processes. Stakeholders provided anecdotal evidence of the limited intervention and knowledge of the known consumer’s requirements and care plan. Stakeholders suggested the triage line has limited ability to refer to community based supports with significant numbers of callers being referred to the emergency department. Some stakeholders suggested a return to localised triage at the team/catchment level – the costs and benefits of this revision were out of scope of this project but could be considered in future cross LHN work.

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However, other stakeholders reported the implementation of the 8 hour referral target category had led to more appropriate prioritisation of consumer home-based assessments. It is timely to review the benefits, outcomes, skill sets and structures for the mental health triage line given the evolving nature of the primary and specialist community mental health systems.

**Recommendation 5: Model and staff acute and ongoing community streams based on likely daily/weekly referral patterns and needed transfers back to primary care or self-management**

The predicted referral patterns for acute and ongoing community support should be modelled for each team. Staffing models should be flexed to allow for likely referral demand. There should be targets set and monitored for planned transfers back to primary care, NGOs and private providers. Without clear targets and transfer management caseloads will become unmanageable.

Expected dates of transfer should be set early on in the course of care and these expected dates communicated to consumers and carers at appropriate points. Consumers reported the discussion of expectations of case closure came too late in the episode of care to allow them to develop the confidence and skills to move to the next step of community care.

**Recommendation 6: Support the development of rapid access assessment function in each community team, including for stable SAAS transfers**

The ability for primary care, SAAS and self-referred consumers to rapidly access community-based and skilled assessments is key to managing flow and ED avoidance. Same day crisis response assessment should be available via the community team, but will normally be provided by the crisis resolution/home treatment team.

Everyone who is referred should usually be assessed, even if the assessment may lead to advice and supports being suggested external to the SCMH team. It will not always be possible to limit assessments to severely mentally ill – GP skills vary and advice on the management of common disorders and also confirmation that people are not suffering from psychiatric disorder is part of the service. Most assessments of those with severe mental illness should involve trained medical staff. Those with common mental health problems may more appropriately be assessed by other team members.

The outcome of the assessment should be communicated to patient and referrer promptly with the consumer and carer involved in the assessment whenever possible. This will assist with recovery and the consumer building an understanding of their situation, specific needs, diagnosis and treatment options.

**Recommendation 7: Identify the community based specialist skills and support required for each phase of care while allowing SCMH health professionals to practice at ‘top of scope’**

There are significant benefits of the health discipline specific skills that exists within the multidisciplinary SCMH team. Currently the skill sets of Allied Health and those with advanced skills in specific clinical therapies are underutilised. This impedes the consumer’s recovery journey and increases the length of the care episode. However, placing every consumer with specialised services is likely to lead to over servicing and not meeting the individual consumer’s needs and goals.

A more balanced approach to identifying and matching consumer needs to the core and specialised skill sets is required. A skills assessment and capacity development based on key skill gaps identified in the team should occur. This would follow the defining of SCMH core business and the standard therapeutic interventions to be provided by SCMH services.

Allowing staff to practice at the top of their scope of practice will enhance morale and staff retention. It will also lead to better outcomes for consumers and likely to shorten the length of period of support. In doing so there will be a need to stratify consumers into those who would do well with a more generic core skill set approach to those requiring more specialised interventions in order to prevent over servicing or excessive caseloads for those with specialised skills. Investment in the development of advanced psychological therapeutic interventions in addition to staff core skills in care coordination was identified as key to the future of SCMH – through the future state workshops, qualitative interviews, process mapping and staff survey.
Recommendaition 8: Implement mechanisms for review of consumers after a set number of sessions with early discussion with consumers and carers of progress and transfer to shared care

While case review is planned to occur every three months the fidelity to timeframe and content of the review varies. Stakeholders reported challenges in accessing community psychiatrists' registrars with knowledge of the specific consumer’s needs. Continuity of care was raised as an issue by both staff and consumers.

The review process should occur regularly with monitoring and discussion of consumer progress and outcomes. Consumer and carer involvement in these reviews should be the default position. As part of the recovery focus consideration of the requirements and likely timeframe to move to the next phase/step of care should be embedded into every review. There will be times when SCMH support is considered restrictive or not the most appropriate service to promote recovery. Clear understanding as to when and how to involve others in the care and support process should be considered need to be documented and adhered to in the best interest of the consumer’s recovery journey.

Care plans for those with severe mental illness should be formally reviewed and updated at a frequency determined by need: this should be regarded as an ongoing process, which can be initiated by any member of the care team or the user or carer.

Recommendaition 9: Enhanced primary care and NGO interfaces and capacity development support

SCMH provided by public mental health services has a key role in supporting the broader health and human services systems to promote mental health recovery, wellness and optimal community tenure. This does not mean SCMH needs to provide all things to all people and consumers. Rather they have the ability and functions to be able to build the capacity of NGOs, primary care and private providers to develop, implement and support care planning without the need for long term engagement of the consumer with the SCMH sector. LHNs should explore, in conjunction with the Primary Health Network and other stakeholders, the best ways to provide this capacity development function and support. There should be the ability for GPs to rapidly access telephone and tele-health psychiatrists and other SCMH expertise.

Recommendaition 10: Implement ‘Shared Care’ as default for all ongoing care consumers

The impact of comorbid physical, metabolic and mental health issues is well known. These co-morbidities significantly impact Mental Health consumers’ life expectancy and quality of life. Shared care should be considered a minimum standard approach. Shared Care, with strong engagement with GPs, assists in the reduction of the impacts of comorbidities.

Decisions as to the usual ‘recovery and wellbeing consumer care home’ should be decided in conjunction with NGOs and primary care providers. This will assist with allocation of the responsibility of care coordination, interfaces between care and support providers and possible reduction in the length of each phase of care.

Recommendaition 11: Consider the trialling of community transfer of care positions in each SCMH team to facilitate shared care and closure of long stay maintenance consumers

The current capability and capacity of SCMH teams to focus on transfer to primary and other care providers is limited. Staff universally reported limited knowledge of the other service options available to support shared care.

During this period of transition to a greater stepped model of community care LHNs should consider trialling and evaluating the benefits of expert positions in transfer of care. These positions would have a focus on capacity development in relation to transfer of care within SCMH as well as supporting the primary care sector to better respond to ongoing consumer needs.
Recommendation 12: Streamline care plans and reduce the amount of time required for documentation

The majority of staff and stakeholders reported the current documentation and care planning requirements to be overly cumbersome, time consuming and not fit for purpose. The level of care planning and documentation should be responsive to consumer complexity, phase of care and needs. A cross LHN working group should be established to rapidly review and refine the documentation requirements and procedures. This will aid in increased direct care time.

Recommendation 13: Investigate refinements to CBIS functionality, including the ability for CBIS to be converted to a full electronic medical record prior to full implementation of ePAS

CBIS functionality and accessibility was universally identified as a barrier to direct care time. Within the parameters of restricted budget and the longer term move of services to ePAS, CBIS should be refined and enhanced as much as possible. This should include investigation of the balancing of audit trail requirements and functional ability to the need to reduce the non-value added activities of printing and filing copies of care plans and entries to paper files. This latter issue was described as one of the most significant barriers to increased direct care time.

In addition, staff suggested the following refinements to CBIS:

- **Usability Related Issues** - Staff have complained that the design and layout of the screen makes CBIS difficult to use. Staff have to often exit the main screen they are looking at and enter a specific different screen to enter or view any information about specific aspects of the consumer. Thus, at a glance it is difficult to know what to update about every consumer. To get a ‘dashboard view’, staff have to run specific reports and several staff are not well versed in knowing the purpose of each report.

- **Irrelevant Fields Present** - Staff have stated that the relevance of many of the fields regarding a consumer’s condition is questionable. A more detailed analysis needs to be conducted to determine which information is absolutely essential and streamline the collection and display of information.

- **Relevant Fields Not present** - CBIS does not interface directly with the HAS (Hospital Admission Systems), including ePAS. As a result, it is hard to track certain metrics such as the referral rate from hospital ED, as well as the proportion of consumers in the Acute system who also have an open Community MH episode. Other relevant fields that are not present include:
  - Primary Health Information – GPs
  - Information about NGO Packages – The fields are present to collect this, but not kept up to date. CARS provides more relevant information about the NGO packages.
  - Information about Estimated Remaining Duration to enable forecasting and planning for future capacity
  - Information about other Private services sought by the consumer – e.g. Private Psychiatrist etc.

- **Accessibility** - CBIS is only accessible by Mental health workers rather than SAAS, ED and other care providers. In addition, staff are unable to access CBIS when visiting a consumer in their dwelling or other facility outside a CMHT’s offices. Several staff have also struggled with understanding how to use CBIS beyond the basics and training on using the program might assist.

Recommendation 14: Implement Community dashboards with targets and of flow expectations

Currently the performance, caseloads and outcomes achieved by SCMH is not transparent. An agreed set of SCMH KPIs and a dashboard which is available at the individual, cluster, team and LHN level is required. KPIs should include the average length of the phase of care, the numbers of weekly transfers/discharges from SCMH and the timeframes between referral, assessment and intake.

Recommendation 15: Invest in the development of frontline team managers to understand flow, accountability and performance management

The SCMH sub-teams should be developed and supported to have a greater level of self-accountability and performance monitoring. Key working principles for a high performing team should...
be developed and embedded with each sub-team to allow levels of greater autonomy and peer/team accountability.

The size and discipline mix of sub-teams should be considered by LHNs. There may be benefit in smaller self-monitoring teams which cover a specific function, stream or catchment. The size may be somewhere between 8 and 14 FTE – the latter figure supported by the National Mental Health Service Planning Framework.

4.2. Next steps

The project has provided a significant number of reform and redesign suggestions for consideration by LHN and state Mental Health leadership. The mechanisms for implementation of any culture and leadership/management development initiatives also need to be considered and investigated.

4.2.1. Cross LHN agile working groups

A number of the recommendations require a cross LHN approach to ensure consistency in approach and relationship with external providers. The development of small working groups with expertise in community mental health and operational impacts of any changes is suggested. These should take an agile implementation approach with the aim of trialling of solutions within the next 2 – 3 months.

The following recommendations lend themselves to cross LHN working groups:

1. Define the core business of Specialist Community Mental Health in line with refined primary care models and commissioned services
2. Revise the current community mental health business rules to provide a more flexible framework and define those items that need standardisation
3. Enhanced primary care and NGO interfaces and capacity development support
4. Streamline care plans and reduce the amount of time required for documentation
5. Investigate refinements to CBIS functionality, including the ability for CBIS to be converted to a full electronic medical record prior to full implementation of ePAS
6. Implement Community dashboards with targets and of flow expectations

4.2.2. LHN specific implementation plans

LHN’s should review both their locally developed solution ideas and the suggested overarching recommendations. Local implementation plans will need to be developed following consideration and acceptance of the recommendations.

4.2.3. Local LHN leadership and project governace structures

Rigorous controls and project management structures will need to be implemented to progress the local solution and cross LHN recommendations. It is suggested a full time project manager is employed in each LHN to progress the implementation. Governance structures are in place in NALHN which would meet implementation project governance requirements. These would require further refinement in CALHN and SALHN.
Appendix A: CALHN summary of forum
For permission to access the workshop materials and output report please contact CALHN MH Executive Director and CALHN MH clinical lead.

Appendix B: SALHN summary of forum
For permission to access the workshop materials and output report please contact SALHN MH Executive Director and SALHN MH clinical lead.

Appendix C: NALHN summary of forum
For permission to access the workshop materials and output report please contact NALHN MH Executive Director and NALHN MH clinical lead.

Appendix D: Key barriers and enablers
Against each opportunity, key barriers and enablers were identified. The barriers and enablers have been specified for each opportunity identified in each LHN. This report summarises the main types of barriers and enablers identified. An enabler represents something that will make the opportunity possible, while a barrier is something that currently exists and/or has the potential to prevent/impact something from being achieved.

Table 6 outlines the factors identified as standout barriers and enablers.
### Table 6: Barriers and enablers to achieve opportunities for the CMHTs

<table>
<thead>
<tr>
<th>Factor</th>
<th>Enablers</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>1. Clear strategy</td>
<td>A clearly defined and communicated vision was which assist design other aspects of the service, manage workloads and ensure best consumer care.</td>
<td>Currently changing objectives, a state-wide policy which is not finalised and a view that there is a focus on a medical model are barriers to achieving change.</td>
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<td>2. Clearly defined roles, and responsibilities</td>
<td>A large number of enablers were identified under this factor. Clearly defined roles and responsibilities within CMHTs and other organisations is seen as a significant enabler. Clear portfolios for staff, documented skills matrixes of teams, and the involvement of the appropriate team members are all viewed as important enablers. Consistency of psychiatrists in consumers care was also noted as an important enabler to the model of care opportunities.</td>
<td>Variation and disagreement on who is accountable and responsible according to training and skill sets</td>
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<tr>
<td>3. Cultural change/enhancement/encouragement</td>
<td>Overall it was acknowledge that there needs to be a focus on supporting CMHT to enhance and improve the current culture to support the significant changes proposed. The change management process needs to support the sense of team work and ethical management.</td>
<td>A number of the opportunities require CMHTs to accept some measured risk where they currently might be highly risk adverse, i.e. discharge planning. This risk aversion was touted as a barrier to change. Currently some CMH team members identified that limited autonomy, pockets of lack of trust, resistance to change as well as the pace of change proposed are current barriers to opportunities being realised.</td>
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<tr>
<td>4. Design of processes, practices and pathways</td>
<td>Enablers to improving the design of processes, practices and pathways includes looking to evidence based practices, detailed reviews of current processes, a focus on standardisation and streamlining, clearly defining and educating employees on these processes, practices and pathways, agreement and consensus from CMHTs, monitoring of adherence are important. Particular areas which were strongly called out for designing processes, practices and pathways were consumer pathways, discharge planning and trigger(s) of escalation and de-escalation of care</td>
<td>The limited transparency, clarity around current processes, practices and pathways, the manner which some are designed, the localisation and complexity of processes, practices and pathways are barriers which need to be overcome to achieve change. Specific examples of barriers include restrictions on KPIs / business rules, fixed entry criteria and limited safety nets to stop clients 'slipping through the cracks'.</td>
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<tr>
<td>Factor</td>
<td>Enablers</td>
<td>Barriers</td>
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<td>5. Enhanced engagement with consumers</td>
<td>Goal setting with consumers, enhanced focus on being consumer based, ensure a care plan is completed for all consumers and information sharing with consumers were all identified as important enablers to improving the functioning of CMHTs and the support provided to consumers.</td>
<td>Managing patients’ expectations and some external support services only being available to consumers enrolled in CMHTs were seen as barriers to change.</td>
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<tr>
<td>6. Information/Data/systems</td>
<td>Improving the information collected and the functionality of data systems enablers a significant number of opportunities identified. For example it assists freeing up CMHTs time for value-add services, understanding consumer base and consumer history and current need, ensuring timely and safe care. Specific enablers involved onsite IT/CBIS support, enabling documents to be scanned into electronic files have been identified. CMHTs can look to other organisations who have similar profiles to their solutions i.e. (i.e. RDNS uses “commcare” system, SAPOL)</td>
<td>Current information systems are a barrier to change. The unreliability and limited access to EPAS, as well as information systems not supporting core business and information sharing are important concerns in the current system. Further, if a new IT system is implemented a barrier would be transferring historical information.</td>
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<tr>
<td>7. Links with and information about other organisations</td>
<td>Understanding the skills and services offered across the service system is a key enabler. This includes streamlining pathways to refer to supporting organisations. Specific examples of enablers include a centralised database of NGO services, formal links such as MOUs, clear acceptance criteria and localised triage.</td>
<td>The lack of statewide service criteria was noted as a barrier, particular to managing demand and discharge planning.</td>
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<td>8. Staff training, development and use of expertise</td>
<td>Team training, skill development (i.e. motivational interviewing), staff specialist, champions, mentorships, dedicated professional time, recognition of employees’ special interest and clearly document skill matrixes are key enablers.</td>
<td>Current role restrictions and limited competency based training are key barriers.</td>
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<td>9. Stakeholder engagement</td>
<td>Engaging employees, consumers and carers is pivotal to the success of the reforms. Suggestions such as 360 degree feedback and ensuring safe environments to provide input were provided.</td>
<td>Poor communications</td>
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<tr>
<td>Factor</td>
<td>Enablers</td>
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<td>10. Supports</td>
<td>Support such as brokerage, advocacy, involving peer workers, community mentors, involvement of clinical co-ordinator / transfer of care workers will all support opportunities. Tools such as decision making trees, and improving brokerage and tendering processes are supports which will enable change.</td>
<td>Administration as a separate team with separate management and a lack of consulting rooms to see consumers in are notable barriers.</td>
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<td>11. Workload management</td>
<td>A focus on managing workloads and tools such as time quarantined on Scheduler</td>
<td>CMHTs capacity, staff burnout, the requirement to share roster/team duties and meeting fatigue are all current barriers.</td>
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<td>12. Types of care</td>
<td>Flexible home visits and developing consultancy approach (plan about who can come back)</td>
<td>Lack of organisational commitment to define guidelines</td>
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<td>13. Adherence to processes, practices and pathways</td>
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<td>Implications of the roll-out of the NDIS, competition between NGOs for contracts, waiting lists for other services, lack of control over other organisations accepting/support consumers and the current variation in the liaisons/links between CMHTs and other services were barriers to current opportunities, particularly around improving demand, flow and discharge planning</td>
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<td>14. Availability/interface with other services</td>
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<td>Overcoming the significant and complex nature of consumers and their families and carers is a notable barrier. For example consumers who are socially isolated or do not have family support are difficult to discharge, further overcoming consumers unwillingness to be discharged is a barrier and consumers who mistrust processes to re-enter the services.</td>
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<td>15. Challenges faced by consumer/family/carer</td>
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<td>Requirements for privacy and confidentiality might limit solutions to information and data system improvements as well as sharing information with other services.</td>
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<td>16. Complex nature of problems/consumers/system</td>
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<td>Limited funding, resources (i.e. rooms to see consumers) and particular employee types are a barrier – for example full-time psychiatrists.</td>
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<td>17. Privacy and confidentiality</td>
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<td>18. Resource/funding</td>
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