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<th>Gayle Goodman, Clinical Services Planner, Mental Health Directorate</th>
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<td>Review of Rehabilitation Services</td>
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Document history

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<td>Kathryn Zeitz</td>
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<td>Review Group - See Terms of</td>
<td>Transforming Care Central Adelaide LHN Rehabilitation Services Review</td>
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Introduction

Central Adelaide Local Health Network (Central Adelaide) Mental Health Directorate (MHD) is undergoing a period of change in the context of the State-wide Transforming Health initiative, the Central Adelaide Commitment to Care and our Directorate’s own current planning strategies including proposals for changed structure and governance of the service as whole.

The matrix below encapsulates the drivers for all this work and the changes associated.

These changes are aimed at our aspiration of ensuring the “right service for the right person at the right time in the right place, by the right people” as part of our Clinical Redesign and Commitment to Care.

Similarly, the draft changes to structure and governance for the Directorate are founded on the concept of Single Service Multiple Site.

Rehabilitation Services across the directorate are part of this commitment, and for this reason it is timely to review how we deliver this aspect of care, considering how we support consumer’s recovery:

> Ensuring timely access to Rehabilitation input for all consumers requiring this approach to care (right service, right time, right place) - Transforming Care.
> Clearly identifying where and how this fits in the Continuum of Care as part of an integrated service - Supporting Care and Enabling Care.

In undertaking this review we are seeking to answer the following questions:

> Do the right people get the right service?
> Do they get it at the right time and in the right place?
> How does this fit into the plan for the Central Adelaide MHD?
> How do we provide recovery focused rehabilitation into the future?

Scope

Included in this review:

> Western Psychosocial Rehabilitation Programs (WPRP): A community based service offering a range of goal focused groups, variously pitched to address a range of needs and stages of recovery; reviewed specifically in 2013.
> The Cottage: A community based service offering a range of goal focussed groups, variously pitched to address a range of needs and stages of recovery.
> Elpida House CRC: A residential rehabilitation focused unit, located in the community, offering goal focused individual programs with 24 hour clinical and psychosocial support utilising Clinical, Community Rehabilitation Workers (CRW) and Peer Specialist staff.
> ShAC: Shared Activities Centre, attached to Inpatient Rehabilitation Services. Provides structured programs in specialist areas of music, art and gym.
The review considers:

> **structure and governance**: How the service is managed and how is it accountable

> **resources and capacity**: What resources are represented (staff and goods/services) in the service and how many people can benefit

> **role and operations**: where do these services fit in to the directorate as whole, how does it interface with other stakeholders, including other aspects of the directorate as well as the community more broadly? What are the processes: from referral to care and transition planning?

> **accessibility**: Who receives the service, who doesn’t and where do referrals come from?

> **output and effectiveness**: including consumer and group outcomes, KPIs, stakeholder feedback, repeat referrals

> **current issues**

> **options and recommendations**.

It should be noted, the four services in scope represent three very different aspects of service despite the shared badging of “rehabilitation”. Due to the differences, in many instances the elements for review identified above will need to be addressed separately.

It should be further noted that Inpatient Rehabilitation Services are not in scope as they represent a State-wide service (not Central Adelaide). Similarly Rehabilitation Services provided by the NGO sector are not in scope as they are contracted by and accountable the Mental Health Unit.

**Review Process**

The review was initiated by the Service Manager, Eastern Mental Health Services and overseen by a senior group with particular involvement or responsibility for Rehabilitation Services. (Terms of Reference – Attachment 3).

The review sought information through three primary sources:

1. Existing documentation was identified, including overarching frameworks and models as well as a range of operational documents that guide everyday practice.

2. The review has sought quantitative data, drawing on CBIS and manually collected data. Standard Activity reports, generated each month were examined as well prewritten reports available on the browser for CBIS, in particular, the MA7. Specific reports were also requested to try to understand the clientele and services provided more thoroughly.

   There were limitations in analysing this data for a range of reasons. For example, some people accessing community psychosocial rehabilitation services also had an open episode with another team and some data relates to services and actions completed by that other team. CBIS reports are written differently for different services, inpatient services are recorded differently and so on.

   In addition, using the outcome measures (NOCC collection) is also limited. Average HONOS on admission contained in routine Activity Reports for that service cannot be compared to average HONOS scores completed at episode closure as they will not necessarily be the same people. This is further compounded by the situation where a different team (primary team) may be completing the NOCC and the perspective and context for observations may be different.

   Staff / resource data was provided by team managers and finance.

3. Qualitative data was collected using two online surveys. The first was available to all CALHN MHD staff, announced via a bulletin from the Director Strategic Operations and followed up by Service Manager East (Review Lead) and Service Manager West. 51 responses were received.

   The second survey was conducted using an assisted interview approach with an identified cohort of consumers who were known to have used at least one of the services reviewed. All clinical staff were asked to assist with encouraging consumers with current open episodes in any service to complete the survey, however, only 26 responses were received, all from one or other of the services in scope.
Both surveys sought to explore what people understood by the term “rehabilitation” as well to collect thoughts on when, why and for whom these services are provided. Both surveys also asked for thoughts about how the service should develop in the future.

In addition the review team have met with managers of individual services and staff in some instances and gathered anecdotal evidence where relevant.

The review has also been in the context of recent Mental Health Directorate planning activities.

The Review

The review begins with an agreed definition or concept of what is Rehabilitation and what is the expectation of the services in scope. This is discussed and expanded in the, State-wide document *The Framework for recovery-oriented rehabilitation in mental health care* (SA Health, 2012) which accepts the World Health Organisation (WHO) definition defined as:

‘… a process aimed at enabling [people who experience disabilities] to reach and maintain their optimal physical, [spiritual, occupational,] sensory, intellectual, psychological and social functional levels. Rehabilitation provides [people who experience disabilities] with the tools they need to attain independence and self-determination.’

Rehabilitation is much more than re-learning to do something. It also encompasses processes, skills and strategies aimed at supporting individuals to develop skills for the first time. Strategies and interventions that assist individuals to acquire new skills and build on their current skills necessary to participate in all domains of their life are also vital components of rehabilitation.

The Framework also seeks to illustrate the breadth of rehabilitation by identifying different emphases.

Types of rehabilitation services commonly accessed and available to people with lived experience of mental illness include but are not limited to:

> psychosocial rehabilitation  
> vocational and educational rehabilitation  
> drug and alcohol rehabilitation  
> physical rehabilitation  
> clinical rehabilitation.

Components of the recovery-orientated rehabilitation services named above often combine and/or overlap. It should not be assumed that they operate in isolation from each other.

Structure and Governance

Guiding documents

The review sought to examine existing directive documentation including Models of Care, Frameworks, Operational Guidelines or similar and found a range of documents.

> At an overarching, State-wide level *The Framework for recovery-oriented rehabilitation in mental health care* (SA Health, 2012) exists. This is significant work which addresses concepts, definitional matters, principals and broad approaches to practice with a particular emphasis on the relationship between rehabilitation and recovery.
The Integrated Model of Care 2011-2014 was developed to guide the establishment and operation of the Glenside New Health Facilities (now known as Glenside Health Services) and incorporates principals and pathways for Inpatient Rehabilitation Services. It references the Shared Activities Centre but does not address specific operational matters.

The Community Rehabilitation Centres (CRC) (three across metropolitan Adelaide) were established under the guidance of a Model of Care and various versions of Operational Guidelines have been developed since. These guidelines have been reviewed in the past year, led by the Service Manager for the Outer South but have not been widely promulgated. It seeks to set the context for the CRCs, define pathways and describe various aspects of rehabilitation and operational principles. It is a comprehensive document, with considerable detail on these aspects of the service.

The Clinical Psychosocial Rehabilitation Programs Service Description, undated, but compiled in late 2012-early 2103, was a work undertaken by the managers of those services, including two similar services operating in the North and North Eastern sectors, in recognition that such a document did not exist. It sought to articulate principles and practices across the four operations to promote consistency as well as enhance the pathway and accessibility for consumers.

This work was undertaken by the managers in good faith but has not been formally endorsed at any level of governance and has no status.

All four services in scope also use a range of OWIs and process documents to support practice.

Over the years following the Stepping Up Report (Stepping Up: A social inclusion action plan for mental health reform 2007-2012), and during the course of various restructures of mental health services, interested parties have sought to establish effective guiding documentation for rehabilitation. For the main part, however, this work has been localised, had restricted scope and of limited status.

It is worth noting that feedback from the staff survey noted a lack of a cohesive framework for rehabilitation within and across the MHD.

Positioning of rehabilitation services in the organisational structure

Our current suite of rehabilitation services in scope for this review is split operationally between the eastern and western sectors. Elpida House (CRC) and the WPRP in the west, are under the jurisdiction of the Service Manager West; ShAC and the Cottage under the Service Manager East. (See Attachment 1)

The three discreet services (WPRP, the Cottage and Elpida House) are each managed by a Team Manager or Team Leader, who reports directly to the (operational) Service Manager of the region in which they are located.

Team managers are multi class positions AHP4/RN3.

WPRP and Elpida managers are 1.0 FTE and the Cottage 0.5FTE. One of these is currently held by an Occupational Therapist, the other two by Social Workers.

Within the teams all staff report directly to the team manager who is responsible for operational aspects of the service. Usual professional supervision and reporting lines are in place as across the directorate as a whole.

The ShAC is also managed by a Team Manager, but as part of the larger Inpatient Rehabilitation Services. This person also reports to the Eastern Service Manager. The position is multi-class, but at AHP4/RN5. (The disparity in classifications across nursing and AHPs is noted but not addressed in this review.)

ShAC staff includes the music therapist, art therapist and senior gym instructor – who supervises two other instructors. These staff have professional links to the Allied Health Directorate of Central Adelaide with some level of supervision or oversight provided by the Principal Occupational Therapist. The clinical allied health staff of Inpatient Rehabilitation Services including the occupational therapists, social workers and psychologists, are not considered part of the ShAC.

Capacity to differentiate aspects of the ShAC from Inpatient Rehabilitation Services for the purpose of this review has been limited.
Strategic positioning

There are currently no overarching structures supporting rehabilitation services across the directorate, operationally or strategically. While the services are encompassed in overall strategic operational planning for the Central Adelaide MHD, application of strategies or specific expectations in relation to the vision are either limited or addressed at a local level.

Few processes are shared and approaches to service or team development is mostly team based.

In situ is:

> A state-wide group that meets periodically regarding the development and operation of the CRCs, led by the Service Manager of the outer south. This group was established under previous health structures and the then Adelaide Metro Mental Health Directorate.

> A shared allocation group processes requests for resources for both inpatient rehabilitation (as a bed based service, not specifically for ShAC) and the CRC as well as NGO provided psychosocial rehabilitation (IPRSS, HASP, Supported Social Housing etc). These are services that also have a state-wide basis and the allocation group looks to balance resource use and priorities.

There is no formal connection between the two community based psychosocial rehabilitation programs, which as noted above, report through different Service Managers. Nor are they connected via any structure or formal pathway with other elements of rehabilitation provided by the Central Adelaide MHD.

Again the staff survey feedback noted an absence of a plan or framework for rehabilitation that draws on theory and evidence. There were strong suggestions around the value of a more coordinated, integrated and contiguous approach to rehabilitation services within the context of the service as a whole.

Accountability

Monthly activity reports are generated for the CRC and available on the intranet. A similar report is produced for Inpatient Rehabilitation Services but does not contain data specific to the ShAC. The monthly activity reports for the community teams, also on the intranet, do pick up activity data for the WPRP or the Cottage but the information is somewhat generic and of limited value. In addition, there are pre written reports within the CBIS report browser. However, extracting meaningful data relating to output or outcomes, is difficult, coming with multiple caveats as referred to earlier.

In line with the proposed restructure of Central Adelaide MHD and the creation of pillars and portfolio responsibilities for senior managers, there is opportunity to create a rehabilitation portfolio.

Such portfolio would take a MHD wide approach to operational and strategic development for a clinical rehabilitation service that is integrated with the community and inpatient care.

This would include a mandate to operate less introspectively with an approach that extends actively and formally where necessary, to develop relationships and partnerships with an array of external services as well as other elements of mental health services.

Drawing on the endorsed state-wide framework, a system wide set of principles and pathways could be formulated that demonstrate the interactions between all aspects of clinical rehabilitation as well as other clinical, treatment and coordinating services and functions.

This would include identifying existing and required OWIs to support effective operation within the larger system. It would be an exercise in collection, assembly and editing, drawing on previous works. Gaps would be identified and addressed as needed.

This work should also articulate the roles and interactions with external providers, including non-government organisations.

Meaningful outcome measures and KPIs specific to rehabilitation services need also to be developed.
## Resources and capacity

<table>
<thead>
<tr>
<th>Team/ service</th>
<th>Staff number FTE &amp; Head count</th>
<th>Discipline mix Including admin (FTE)</th>
<th>Budget W&amp;S G&amp;S (Inc rent)</th>
<th>Hours of operation</th>
<th>Ave LoS for discharged consumers KPI LoS</th>
<th>Referrals per month (ave last 12 months)</th>
<th>Ave number of open episodes per month</th>
<th>Ave Service hours provided per month</th>
<th>Ave transfers / month</th>
<th>Capacity</th>
</tr>
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<tbody>
<tr>
<td><strong>WPRP</strong></td>
<td>8.1fte 12 staff</td>
<td>OT SW Nurse Psychology Lived experience Activity supervisor Team manager (multiclass)</td>
<td>$667,000 W&amp;S $177,000 G&amp;S (inc rent)</td>
<td>9.0am –5.00 pm Monday - Friday</td>
<td>Ave LoS over 12 month period 214 days</td>
<td>9.7 internal only 10 including external</td>
<td>116</td>
<td>692 direct hours contact + indirect = 727 total hours 250 over a 12 month period 375 individual group contacts (ave/month)</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td><strong>Cottage</strong></td>
<td>3.63 FTE 5 staff</td>
<td>OT SW Nurse Psychology Lived experience Admin Team Manager</td>
<td>$353,000 W&amp;S $59,000 G&amp;S</td>
<td>Mon – Fri 0830 - 1630</td>
<td>Ave LoS over 12 month period 228 days</td>
<td>4.5 internal only 5.6 including external</td>
<td>59</td>
<td>347 direct hours contact + indirect = 363 total hours 134 in a 12 month period 200 Group contacts ave (individual attendances)</td>
<td>3.25</td>
<td></td>
</tr>
<tr>
<td><strong>Elpida House</strong></td>
<td>19.0 FTE 22 head count Not inc casual CRWs</td>
<td>OT SW Nurse Psychology Lived Experience Admin Team Manager CRW</td>
<td>$1,793,000 W&amp;S $203,000 G&amp;S</td>
<td>24/7</td>
<td>Ave LoS over 12 month period 260 days</td>
<td>Av. 2.3 entries of consumers per month (July-June 2014-15 (CBIS)) 91% average occupancy per month</td>
<td>24/7 service 360 hours ave direct contact 381 total Service based contacts</td>
<td>2.3</td>
<td>20 bed facility. Combination male/female ratio.</td>
<td></td>
</tr>
<tr>
<td><strong>ShAC</strong></td>
<td>3.6 FTE</td>
<td>Gym instructor* Music therapist Art therapist</td>
<td>$373,000 W&amp;S $26,000 G&amp;S</td>
<td>Mon-Friday</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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**Sources:**

- Staffing: individual Team managers/ team leaders
- Budget: Business Manager
- CBIS MA7, 01/09/2014 – 31/08/2015: LoS, internal referrals, hours of service(WPRP, Cottage & Elpida only)
- Monthly Activity Report: Elpida
Table 1 sets out the combined resources attributed to the range of rehabilitation services in scope and limited performance data.

*Note: The senior gym instructor also provides services to James Nash House 0.2 FTE.

There is no attempt here and is not the scope of this review to evaluate individual services. The intent is to examine the service from a system perspective to determine how it works, where, with whom and to what end we offer rehabilitation services as a portion of our resource deployment.

**Role and operations**

**Referral and Intake**

As noted previously, referral to the CRC and to Inpatient Rehabilitation Services (the only access to ShAC) is aligned – using a common application form and process, which is shared with applications for a number of NGO based psychosocial rehabilitation services and supports. These are paper based applications forwarded to a committee with senior representation aimed at ensuring appropriate priority of access to limited resources. The committee considers the requests and reasons for the application, seeking to confirm a match between the service requested, the goals, and the nature and intensity of the service for which they are applying.

Referrals are only accepted from within the mental health system (across the metro and country LHNs).

As these services are usually at capacity, it is not unusual for applicants to be placed on a waiting list. This list is reviewed regularly by the committee.

A range of check lists and flow charts support these processes.

In the past year, there is evidence of increased referrals stepping down to the CRC from inpatient beds. Data reports do not distinguish between acute and Inpatient Rehabilitation Services beds but anecdotally this increase is from Inpatient Rehabilitation Services and suggests improved articulation between these two services and a progression of care to a less restrictive option.

Feedback from the staff survey expressed some views that the application process was onerous and time consuming with no guarantee it would be accepted. There were also comments around inconsistency of intake criteria for the CRC with non-rehabilitation based admissions occurring.

Once admitted to Inpatient Rehabilitation Services, there is no formal requirement for referral to ShAC.

Referral to the Western Psychosocial Rehabilitation programs and the Cottage, however, are quite separate and direct. Referrals generally come from within the mental health system but are accepted from GPs and private psychiatrists as well as other community sources.

Internal referrals are completed on CBIS, with the expectation the referring service will have provided the consumer with information regarding the program and the opportunity to visit and participate in the decision.

The two services operate similarly in that they review the referral, apply very broad filters which include a willingness to participate in goal directed activities and risk assessment. From this point the service offers further assessment, exploration of goals and opportunities available.

Although both these services and the various groups conducted there have ceilings on numbers, capacity has historically been available and consumers do not need to wait to access the programs.

It is important to note here as well, that consumers accessing these programs may or may not still be receiving treatment and care coordination from the community mental health team. This has implications in terms of other system obligations such as completion of NOCCs, care planning and review. Where the Cottage or the WPRP are identified as the primary team, a clinician will be allocated as care coordinator.
Service Provision

As it is part of an inpatient service, people accessing the ShAC are receiving all aspects of their care via the inpatient team. However, there is an increasing drive to plan this care in partnership with the relevant community mental health team and the care coordinator. This service is state-wide and this work involves all four location based LHNs. It is important to note that people accessing the ShAC may be in care subject to the Metal Health Act 2009, although access to ShAC is always a voluntary activity.

ShAC staff participate in planning rehabilitation programs and clinical reviews and maintain feedback from ShAC activities in the consumers casenotes. While this occurs in the context of the multidisciplinary team it is not formally aligned to assessments and activities of clinical staff and is not directed by them.

This is possibly an area for further consideration.

CRC operations are different in that the community team are involved and the person’s medical care remains with that team. The CRC team actively seek community team input in all aspects of planning for the goals and implementation of the rehabilitation program whilst the person is resident in the CRC. Clinical and program reviews are expected to demonstrate participation of the consumer and carer, the CRC and the community team care coordinator. While this is the expectation, involvement of the community teams remains variable.

According to data collected, on average, approximately 95% of care plans are updated within a month, however, only 25% have consumer involvement in this.

WPRP and the Cottage - Both of these services run a varied and broad based program of groups which are usually based on school terms.

The groups and programs are aimed at different levels and span a range of rehabilitation goals and intentions. This includes elements as such as direct functional skill development, confidence and social skills, self-management and well-being, including physical health and specific therapeutic input, 1:1 or groups.

There are important elements of outreach and community integration with access/utilisation of general community facilities, cooperation with other providers and involvement in various community activities and events. This is an important strength but possibly underexploited in terms of potential partnerships and tends to initiated and sustained at local level.

Programs are developed with individuals based on their goals and clinical assessments. The persons program is reviewed regularly and where the rehabilitation service is the primary team, the care plan updated and NOCC collection completed. Where the community team is also involved, some efforts are made to link with the individual’s community care plan, participating in those reviews as well.

Over recent years there has been a shift in these programs from ongoing activities and “drop-in” social groups with some consumers attending for years, to a more episode and program based approach with finite involvement anticipated.

There have been some issues with this as the previous arrangement met an important need for some consumers. Equally a portion of referrals come with this expectation and the programs to some extent retain an image of providing for consumers with chronic illnesses.

All rehabilitation services are supported by relevant OWIs and information on processes.

All activity in all services is recorded on CBIS and reported as discussed earlier.

Accessibility

Viewed simplistically, the psychosocial rehabilitation programs are very accessible with a referral via CBIS from other mental health services or directly from a GP or private psychiatrist and capacity is normally available. For the CRC and Inpatient Rehabilitation Services, restricted numbers and anticipated length of stay (LOS) potentially limiting flow mean there is often a waiting period for entry; the detailed referral requirements and the rigorous approach to approval render these services possibly less accessible. Some reduction on LoS for the CRC in recent times has assisted flow.
However, in terms of this review, equally or more important is who accesses the services. In other words do the “right people” receive these as the “right services” at the “right time”?

From a demographic perspective, over a 12 month period, CBIS data indicates a very similar gender and diagnostic profile represented across the in scope services and the community teams. However, the age profile appears somewhat different with a younger cohort represented in the CRC and an older group in the community based programs – WPRP and the Cottage. (Table 2) This is possibly not surprising in view of the history of these programs being accessed largely by people with longer term and disabling illnesses.

If the data is considered for the past four months only (post the establishment of the Youth Mental Health Service) the percentage of people under 25 accessing the service has increased across all teams. CRC to 30%, community teams to 17%, the Cottage to 8% and WPRP to 10%. While this is encouraging, percentage increases are skewed by relatively small numbers for the Cottage and WPRP. Further, it is unknown how many are new consumers to the respective services. The data does not provide evidence of any drive for early intervention.

Table 2
Age profile across services (excluding ShAC)

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<tr>
<th></th>
<th>&lt;18</th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
</tr>
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<tbody>
<tr>
<td>4 community teams - average</td>
<td>1%</td>
<td>14%</td>
<td>22%</td>
<td>24%</td>
<td>22%</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>WPRP</td>
<td>&lt;1%</td>
<td>9%</td>
<td>18%</td>
<td>19%</td>
<td>33%</td>
<td>17%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Cottage</td>
<td>0</td>
<td>4%</td>
<td>15%</td>
<td>35%</td>
<td>29%</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>CRC</td>
<td>0</td>
<td>27%</td>
<td>35%</td>
<td>23%</td>
<td>10%</td>
<td>4%</td>
<td>0</td>
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Source: MA7 01/09/14 – 31/08/15
MA7 01/07/15 -31/10 /15 for under 25

Regardless of the profile of people accessing the range of services badged as “rehabilitation”, it is a very small portion of our population as a whole who in fact are either referred or choose to participate.

In terms of the ShAC, any consumers in Inpatient Rehabilitation Services can access the programs available including those in closed care. (The ShAC is not normally available to consumers outside of Inpatient Rehabilitation Services.) It is beyond the scope of this review to consider who accesses the Inpatient Rehabilitation Services overall but it is noted and offered as a consideration in future planning. Suffice to say the allocation/intake committee is responsible for ensuring that the level of care and support required by consumers is commensurate with their needs.

The same process is applied to access the CRC. However, the question does arise with referrals from the community as to the requirement for a residential approach to rehabilitation and this question is raised in the staff survey.

Looking at the community based psychosocial rehabilitation programs, the picture changes. As already noted these programs are rarely at capacity and often groups are run with very small numbers.
The question arises here as to why, when at any given time there may be between 800 and 1000 consumers with an open community episode in either sector (4,000 in a year), referral numbers remain low despite reported efforts by those services to promote the opportunities available.

The staff survey sought quite specifically to understand how clinicians viewed rehabilitation, where and how they thought it fitted in the overall picture of mental health services.

Results revealed that 89% of the respondents indicated they thought rehabilitation was integral to a person’s recovery from mental illness or that it was a very important aspect of clinical intervention and support. No respondents thought it was not at all important. Less than 10% indicated they did not value rehabilitation services or consider them relevant to consumers.

Similarly over 95% reflected a good understanding of why and when referral to rehabilitation would be appropriate.

While these results are very positive, it should be noted that the findings of the staff survey must be considered with caution as potentially biased. While there were 51 respondents, 14 of those are directly employed in delivery of the rehabilitation services in scope and would be expected to demonstrate a greater understanding and to value more highly the provision of rehabilitation. Of the 36 who identified as either community or inpatient – given the small number and the responses, it is potentially those with an existing interest or understanding who have participated. Only one respondent expressed consistently negative views.

When asked why they might not refer a consumer for rehabilitation, no clear reason emerged. While the strongest response was that consumers are not interested, less than half (47%) thought this. That rehabilitation has an “image problem”; programs are difficult to access; programs are not what is needed; or consumers don’t like groups also scored higher with between 30 - 40% agreeing these are reasons they do not refer.

Both the Cottage and WPRP report regular efforts to keep other areas of service informed of programs available and to seek input on what is needed, however, managers of both teams indicate limited response. This supports the possibility that survey respondents are staff with an existing interest in or commitment to rehabilitation.

Efforts are also made to canvass consumers who have been referred but not engaged to seek information on what would have been better or more acceptable for them, again with limited success.

Anecdotally, some community staff report not being aware of, or difficulty accessing information about programs offered.

**Output and effectiveness**

All the services in scope collect activity data which is logged on CBIS.

Table 1 (page 9) provides a summary of average hours of service and group contacts.

Drawing on MA7 (CBIS) reports which provide information on the nature and extent of individual consumer contacts as well group occurrences and participants:

> The WPRP and the Cottage, provide an average 33 direct or indirect individual hours of service per person per year. This compares with 11 hours per person for community teams. ShAC and CRC as residential as residential services collect data differently. Outcomes using the NOCC suite are gathered across all services as per protocols. However, these tools are not considered valuable indicators of rehabilitation outcomes and the two Psychosocial Rehabilitation programs have trialled implementing other measures more sensitive to specific rehabilitation goals as well reassessing consumers in some instances. These results are recorded locally.

Group data is harder to analyse but does indicate generally low numbers registered for groups and relatively low attendance. Consumer feedback is sought on groups provided by both the Eastern and Western programs and this is used when developing future programs. It is, however, not incorporated into larger systems for analysis.

While both programs elicit and attempt to respond to consumer feedback, this feedback comes from the existing client group, so does not provide input from consumers who for whatever reason, do not access the service.
Responding to consumer feedback this way has created something of a dilemma where the programs have sought to move to a more goal focused, episode based approach and longer term consumers have wanted to retain the sense of “club” or somewhere to socialise on an ongoing basis.

While Inpatient Rehabilitation Services (not ShAC specific) and Elpida House are measured against the usual KPIs of LoS, NOCC completion and Care Planning and the Cottage and WPRP teams are incorporated into the monthly reports for the community team, there are no specific KPIs for rehabilitation services.

As noted earlier, the purpose of this review was not to evaluate the in-scope services at consumer outcome level specifically and this has not been attempted.

It is recommended that specific KPIs and outcome measures are established for all the services in scope.

Discussion

Across these four rehabilitation services there is evident passion for the service provided and aspiration to support consumers’ recovery from their illnesses. There is a wealth of experience and skills in the fields of activity represented and generally, a willingness to continue to develop the services provided. The recognition of the consumer’s story and journey, their hopes and potential are recognised, with an understanding that mental health issues affect the whole person and the whole person must be considered in rehabilitation.

Consumers who use these services speak of their benefit and value. (Consumer survey, consumer feedback to programs).

Accepting that these services are valuable and relevant:

- Do the right people get the right service?
- Do they get it at the right time and in the right place?
- Are the right people providing them?
- How does this fit into the plan for the Central Adelaide MHD?
- How do we see the future?

In order to answer these questions we need to consider who the “right people” are and what is the right service? When is the “right time and the right place?” How is this decided and by whom?

According to the Framework for recovery-oriented rehabilitation in mental health care (SA Health 2012):

- Best Practice rehabilitation is recovery oriented.

  This implies that rehabilitation activity must recognise the unique and personal nature of the person’s journey

- Rehabilitation refers to the process and the tools that practitioners utilise and provide to people to assist in their recovery journey.

- Rehabilitation should be available in all settings and begin as soon as possible.
- Rehabilitation practices should always encompass purposeful evidence based best practice interventions.
- Rehabilitation occurs on a continuum. All workers need to understand rehabilitation but not everyone needs to be an expert in providing all interventions.
- Rehabilitation enables people to connect and become part of their community and be satisfied and successful in the living, working, learning and social environments of their choice.
- The process of establishing a therapeutic relationship is a part of the rehabilitation continuum. It takes effort and time.
- Rehabilitation is cost effective and reduces requirements for acute interventions.
This would indicate, the “right people” refers to any consumer whose experience of mental illness does or threatens to disrupt their capacity “to connect and become part of their community and be satisfied and successful in the living, working, learning and social environments of their choice” or needs support with these elements in their recovery journey.

The “right service” will be the input that person needs to address the aspect(s) their lives that is/are affected, at a level or intensity on the continuum that reflects the severity or impact of their illness.

As discussed under Accessibility, only a small proportion of our consumers access our suite of rehabilitation options. It may be reasonable to assume these are appropriate but are all the people who would potentially benefit from the service offered access, and if they are offered do they accept it?

**It would appear that many people are not getting the “right service”**.

Bed based Inpatient Rehabilitation Services/ShAC and the CRC target those with greater need: people who need significant input to remain safe and to function at the fundamental levels needed for survival and community tenure. These people are potentially recognised by their deficits or the impact of their illness and the service seeks to address this through referral to bedded services. There is evidence the service has recognised the value of a continuum of rehabilitation input with consumers progressing from Inpatient Rehabilitation Services/ShAC to the CRC, to potentially return to community accommodation, possibly with IPRSS (NGO provided Individual Psychosocial Rehabilitation Support Service) to consolidate or build on skills acquired.

The following schema of mental health needs and the timing of interventions is a well-recognised and often copied illustration that demonstrates that rehabilitation needs are not the preserve of those with long term, chronic or disabling illnesses but should be considered from the time even before treatment commences where it may be preventative of deterioration or the reduce the impact of the illness. Just as the importance of early intervention in terms of treatment is now well understood, so is timely access to rehabilitation deemed appropriate.

Figure 3. Spectrum of Interventions

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Figure 5: NSW Spectrum of Interventions

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The model is based on two assumptions:

1. There are separate stages in the development of mental health problems and disorders and people progress from having no problems to having non-specific signs and then to diagnosable mental illness/disorder. **A diagnosis does not mean the person will experience a mental illness/disorder forever.**

2. There are interventions or actions for the different stages which can contribute to the improvement in mental health outcomes and will assist with limiting disabilities.
To answer the question of the “right time” and the “right place” the review looked at data as well as the views of staff via a confidential and anonymous survey. As previously discussed, respondents indicated an understanding of the above concepts of time and place and attached value to the services in-scope, which would support appropriate or “right” referrals, although again we must acknowledge the small number and possibly biased position of the respondents.

The review also sought views of consumers. Numbers of respondents for this were also low (26) and exclusively people who have used one of the in-scope services. Those people who did respond clearly valued the service and also understood the breadth and relevance of rehabilitation in their journey. It must be acknowledged, however, that consumers were responding in the context of the services they have received or know of, and possibly have limited knowledge of options or alternatives.

While it is reasonable to assume from all this that some “right people” access “right services,” it seems likely that many don’t.

In terms of “right place”, there is now considerable scrutiny of referrals to inpatient rehabilitation and the ShAC, the CRC and other NGO provided psychosocial rehabilitation services to ensure this as far as possible, but only a relatively small proportion of our population require bed based rehabilitation.

More broadly, however, accepting CBIS figures, it appears just 8% of total consumers of the integrated community teams are referred to the community based psychosocial rehabilitation programs and a number of these do not engage with the service.

When we consider “right time”, if we accept the proposition in Figure 3 above which indicates recovery focused rehabilitation is appropriate early, we would expect to be targeting younger consumers, and those more recently diagnosed. However, Table 2 demonstrates this is not the reality. Both community psychosocial programs indicate they have made efforts to attract younger consumers, however, this has been only minimally successful to date.

Clearly if the demand for rehabilitation resources were to increase significantly the current programs would very soon be at capacity. For this reason, consideration of a proactive approach to working with the non-government sector is recommended. This refers not only to the mental health specific providers such as those contracted for IPRSS, but broader community based operations targeting either specific demographic groups (eg youth homeless services) or particular activities aimed at promoting wellbeing (eg. community fitness groups).

Are the right people providing the services?

All the services in scope draw heavily on clinical personnel, which is generally considered a strength. This provides capacity to conduct and reproduce clinical and discipline specific assessments to guide the design, implementation and review of rehabilitation programs. More recently established services, however, such as the CRC and the Intermediate Care Centres (sub-acute), have staffing models which include Community Rehabilitation Workers who provide capacity to support and implement programs. All services in-scope employ staff with Lived Experience although they represent a fraction of their staff group.

A further consideration of “right people” relates to the role and interface with NGO providers of psychosocial rehabilitation and support, particularly in people’s homes (IPRSS, HASP).

These services, contracted to the Mental Health Unit, employ a range of staff, generally at certificate level, relying on clinical input from the integrated community teams.

Beyond the contracted IPRSS, or HASP contracted NGO providers, are a range of other services aimed at psycho social support and skill development, most of whom do not specifically employ clinicians.

There is no suggestion that any of these providers are not the “right people” to do this work, on the contrary, it is proposed that closer working relationships and committed collaboration with other providers (mental health specific and generic) would capitalise on the range of skills available and more efficiently benefit a larger number of consumers.
Current Situation

Strengths

Resources

The four services in scope for this review represent a significantly skilled and experienced, committed, multi-disciplinary, clinical resource including staff with lived experience.

It represents the capacity for sound, evidence based, recovery focused, clinical rehabilitation based on assessment, individual, goal focused program design, utilising a range of therapeutic approaches.

The psychosocial group programs also have accommodation; separate to the community mental health services’ premises, separating them from treatment – a positive thing for many consumers.

ShAC utilise a purpose built facility equipped with gym, music equipment and art facilities.

Elpida House has customised accommodation in a community location with facilities for consumers to progress towards independent living.

Relationships

Some effective relationships have been developed with a range of community health and wellbeing services, networks developed and accessed to benefit of consumers. This includes some partnership approaches and some shared use of facilities/resources. Some of these arrangements are quite long standing, generally based on goodwill and informal arrangements. This is very positive and represents considerable scope to develop further.

Relationships between rehabilitation services in scope and other elements of our service, however, are not as close or as interconnected as might be considered desirable.

Recovery focused

Services have a commitment to, and understanding of recovery in mental health and the capacity to tailor rehabilitation programs or activities to individual recovery goals and aspirations aligned to the persons assessed level of function.

Holistic and person centred

The services are not constructed around treatment and the medical model. This allows for a different relationship with consumers that is less illness focused and more individually directed, across life domains.

Foundation

Solid groundwork exists for a Rehabilitation Care Pathway, “Stepped” with other aspects of care.

Gaps / Issues

Rehabilitation services represent a fragmented and disjointed model of operation

This ranges through all the in-scope services resulting in service elements that do not realise potential and struggle to demonstrate their effectiveness despite efforts by team leaders. Services are insular, efforts are duplicated resources not necessarily shared where they might be and inefficiencies occur as a result.

Contributory factors are thought to include:

> the level, focus and structure of senior leadership over many years
> lack of formal structural and governance connections between the rehabilitation services
> relevant outcomes are not incorporated into reporting mechanisms at organisation level
Many consumers who would benefit from recovery focused rehabilitation intervention do not receive such services

People are not always getting the right service at the right time. This includes the services which strengthen the persons own capacity to live well, manage their illness and participate in the community in a meaningful way.

Contributory factors here are thought to include:

- Lack of awareness/ understanding of programs offered by other MH clinical teams and consumers themselves. Services may be presented but not always positively.
- Services offered do not – or are perceived to not – meet current needs.
- Perception of who are appropriate referrals.
- Time pressure and perceived effort involved to refer to services.
- Limited flexibility in meeting consumers’ needs. For example, rehabilitation services are group focussed or provided within a bedded service with restricted scope to provide services in consumers in own home.
- Specialist services provided by ShAC are largely not accessible to consumers outside of Inpatient Rehabilitation Services.

Opportunities

In view of the strengths and resources represented by these services there is a significant opportunity to undertake a paradigm shift in how the Central Adelaide LHN can assist the recovery of people with mental health issues.

Establishing an identifiable, effective and accountable recovery focused rehabilitation service that is both an intrinsic part of the mental health service and works within formal service level agreements with partner organisations has the potential to influence the trajectory of mental illness for consumers and reduce reliance on emergency and acute services.

This concept implies that a person’s clinical rehabilitation plan, focusing on their recovery goals, would be integral to the treatment and care plan and that involvement in rehabilitation is routine rather than the exception. It does not suggest that the Mental Health Directorate should be the sole provider of rehabilitative input but add value to and draw on other providers.

It postulates that Directorate level, agreements and commitments to work with other organisations in partnerships premised on pooling resources can create a “whole which greater than the sum of its parts” approach to service innovation.

Particular opportunities that should be exploited include:

Youth Mental Health Service

This was established in Central Adelaide early 2015 with the addition of four extra clinicians across the LHN. The South Australian Youth Mental Health System of Care 2012, under which it was established, emphasised the importance of psychosocial, vocational/educational and developmental supports for this age group if we were to truly have an impact on the trajectory of the illness and the future of young people in our care.

It also directed the notion of a “system” approach, founded on the development of partnerships across the Youth Sector (not just the tertiary mental health services). It recognises the importance of assertive and early intervention but not only from the perspective of medical care.

While Central Adelaide MHD are providing treatment services to young people referred and accepted into the service, data suggests we are not addressing broader rehabilitation needs.
High needs groups
This would include people who present frequently at EDs, people with dual/multiple diagnoses and people with chronic and disabling illnesses whose needs extend beyond treatment of symptoms.

Clearly, the resources represented by the services in scope for this review cannot meet all needs for all people. However, coupling the clinical capability with partner organisations in a committed and organised fashion has the potential to either offer services not currently available or extend their reach. For this group of consumers such an approach would enhance the capacity of the Transitional Care team.

Recovery colleges
This is a concept that has been progressively implemented in the UK for some years, is now being adopted in a number of mental health jurisdictions in NSW and is about to commence in SALHN.

A different model has been developed in the US and adopted by Mind Australia in Victoria with plans to commence in South Australia.

The primary shift in focus represented by these establishments is from the person as a recipient of services provided by a mental health professional to a participant in an adult learning environment, utilising the principles inherent in adult learning. The UK, NSW and SALHN models are founded on formal agreements with clinical services, educational establishments, people with lived experience and NGO providers. The services operate as learning institutions with the requisite structures, obligations and expectations and offer consumers a completely new approach to their own care and recovery.

Central Adelaide MHD is in the enviable situation of having a workforce skilled and committed to the provision of rehabilitation services, representing opportunity to expand and develop recovery oriented approaches.

ShAC Opportunities
There is potential to expand the therapy aspect of art, physical and musical therapies to a greater range of consumers that would benefit from these interventions. Development of these opportunities would be reliant on effective leadership to:

> consolidate the infrastructure including current processes
> integrate rehabilitation into the service as a whole, including promotion and education
> enable establishment of true, committed relationships/partnerships.

Recommendations
As already noted, the review has identified two key issues in the provision rehabilitation services within Central Adelaide LHN MHD these are:

1. The structure, governance and operational model for this element of the service.
2. Consumers are not receiving the services, supported by evidence, as cornerstones of recovery.

The following recommendations are aimed at addressing these two issues.

> Realign rehabilitation services under a single leadership model. This will assume a profile and approach to accountability which currently does not exist. (Attachment 2) The leadership will have both portfolio and operational responsibilities for these services. This concept is in accordance with a proposed restructure of the MHD, currently under consultation, although there are some variations. There is also opportunity to consider alignment of other aspects of the service with the rehabilitation portfolio where there is perceived synergy or is otherwise expedient.

> Drawing on existing Frameworks and Models of Care, establish coherent pathways, consistent base processes and business rules for a multilevel single service across the directorate.
> Build an operational model for the Central Adelaide LHN MHD Rehabilitation Service that supports the “Single Service Multiple Site” concept being adopted across Central Adelaide LHN as part of Transforming Care. This should describe a structure that can provide a recovery focussed service that represents a smooth, accessible, continuum of rehabilitation services that may be bed based, location based or home based, according to the consumers need and stage of recovery, across the Central Adelaide LHN catchment area.

Drawing on evidence based practices, the model should describe governance & operational structure as well as detail including: access, documentation, relationship with other aspects of the CALHN MHD, nature of services provided and exit planning.

It should include staffing models and structures with consideration given to extending Lived Experience and CRW workforce with any future capacity.

Further it should introduce relevant KPIs accompanied by a portfolio wide adoption of data collection and outcome measures meaningful in the rehabilitation context.

> The expectation is for a service stream that is identifiable and integrated in the Service as whole. Raise expectations that rehabilitation is integral to thinking from the time of diagnosis. The aim is that rehabilitation is interwoven with all aspects care planning and access assumed – not identified as an “added extra” and with no with barriers.

> The leadership to be responsible (and supported) for development of “rehabilitation thinking” as part of all aspects of the service - just as we consider treatment, symptom management and fundamental matters such as accommodation.

> Reorientation of the service to a stronger outreach focus that proactively establishes and draws on meaningful and committed relationships with other providers, underpinned where appropriate by formal Service Level Agreements. Responsibility for the establishment, development and maintenance of partnerships and collaborations identified as an intrinsic aspect of the rehabilitation portfolio (as identified in Attachment 2) would lie with the leadership.

> As part of the above, develop potential to focus on particular needs groups, for example, young people, frequent users of the emergency departments, other identified high needs groups.

> Explore and develop a plan for the MHD to participate in the establishment of recovery colleges in the Central Adelaide catchment area.

> Further explore the role of ShAC services – to either expand their scope of service delivery or review the name (Shared Activities Centre if remaining accessible only to Inpatient Rehabilitation Services’ consumers).
Operational Governance
Rehabilitation Services - Current

- Director Strategic Operations
  - Service Manager East
    - Integrated Community teams x 2
    - Acute inpatient services
    - Inpatient Rehabilitation Services including ShAC
    - The Cottage
    - Other services
  - Service Manager West
    - Integrated Community teams x 2
    - Acute inpatient services
    - Elpida House CRC
    - Western Psychosocial Rehabilitation Programs
    - Other services
Proposed leadership and governance for Rehabilitation Services

- **Director, Strategic Operations**

- **Leadership Operational, strategic & portfolio**
  - Inpatient Rehabilitation including ShAC and Statewide Rehabilitation beds
  - Elpida House CRC
  - Community Rehabilitation Programs
  - Existing Rehabilitation partnerships: HASP, IPRSS, SSH and CSS. Ongoing development and leadership of new arrangements including Recovery colleges.
  - Other teams/ operational areas as considered relevant
# Transforming Care
## Central Adelaide LHN
### Rehabilitation Services Review
#### Terms of Reference

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Review and document breadth and depth, activity and operation of Rehabilitation Services offered by Central Adelaide LHN MHD, relate this to the continuum of care and offer recommendations. The aim is to ensure that the service is effective, efficient, accessible and meaningful to consumers, is identifiable in the Stepped System of Care and supports MHD Commitment to Care and the Vision. The review should also offer direction for improvement where needed and practical, positive solutions where possible.</th>
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| Scope | In scope are:  
- Shared Activities Centre (ShAC) at Glenside,  
- Community Rehabilitation Centre (CRC) Elpida House  
- Psychosocial Rehabilitation Group Programs  
  - Cottage at Stepney  
  - Woodville Rd, Woodville.  
Review will include:  
- Structure and governance  
- resources and capacity  
- role and operations: including referral process and care/transition planning  
- accessibility  
- output and effectiveness including consumer and group outcomes current issues |
| Executive sponsor | Katherine Zeitz |
| Review Lead | Alison Pickering |
| Reporting relationships | The review group will report to the Quality & Governance committee. The group will inform and be guided by Lived Experience Groups |
| Process/Ways of working | Examination of Models of Care |
| Data collection and analysis - quantitative: |  
- Consumer demographics  
- Pathways in/out – relationship with Stepped model of Care. /continuum of care  
- Numbers and referral source  
- Nature and extent of services  
- Transfers of care on discharge  
- Outcomes |
- Rehabilitation episode duration
- Identification of unmet need

Qualitative data will be sought from stakeholders:
  - Consumers
  - Carers
  - Staff
  - NGO colleagues

**Methodology:**
- Survey,
- Forums
- Direct mail
- Data analysis
- Comparisons with other services

<table>
<thead>
<tr>
<th>Outcome Deliverables</th>
<th>Report:</th>
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<tbody>
<tr>
<td>Service specific as well as overall</td>
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<tr>
<td>Summary of data analysis</td>
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<td>Identification of any issues</td>
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<td>Recommendations</td>
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<thead>
<tr>
<th>Review group membership</th>
<th>Service Manager</th>
<th>Alison Pickering</th>
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<tbody>
<tr>
<td>Coordinator, Lived Experience</td>
<td>Matt Halpin</td>
<td></td>
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<tr>
<td>Principal Occupational therapist</td>
<td>Lisa Varona / Karen Adams Leask</td>
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<tr>
<td>Team Manager WPRGP</td>
<td>Rosetta Cafuta</td>
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<tr>
<td>Manager CRC</td>
<td>Anthony McPhail</td>
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<tr>
<td>Cottage representative</td>
<td>Patricia James</td>
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<tr>
<td>Manager Inpatient rehabilitation &amp; ShAC</td>
<td>Michelle Hilton</td>
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Proxies may be utilised but must be fully briefed prior to attendance

As required:
- Information Monitoring & Performance Mgt Unit Rep
- Other consumer/carer rep
- NGO representative

*James McCance*

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<tr>
<th>Time frame</th>
<th>October 2015</th>
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| Accepted: |   |