

# Adult Community Mental Health Services

(Metropolitan Regions)

Model of Care  
Principles  
Consumer Pathway  
Operational Guidelines  
National Standards

9 April 2010



Government  
of South Australia

SA Health

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## **Legislative & Policy Framework**

- SA Strategic Plan
- SA Health Strategic Plan
- SA Mental Health Act, 2009
- SA Mental Health and Wellbeing Policy 2010-2015, 2009
- SA Health Respectful Behaviour Policy, 2009
- SA Health: Consumer & Community Participation Policy Directive, 2009
- Draft Code of Practice for Authorised Health Professionals, Mental Health Act 2009
- 4<sup>th</sup> National Mental Health Plan 2009-2014
- National Mental Health Standards (draft 2009)
- National Mental Health Workforce Standards, 2004
- Aboriginal Health Impact Statement 2009
- SA Health Statement of Acknowledgement and Statement of Commitment (2006)
- Framework for the Implementation of the National Health Plan 2003-2008 in  
Multicultural Australia: National Mental Health Strategy, 2004

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## Aboriginal People and the Health System

For Aboriginal people, health is a matter of determining all aspects of their life, including control of their physical environment, of dignity, of community self esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

Health is both a fundamental human right and an important worldwide social goal and is defined as a state of complete physical, mental and social wellbeing.

The South Australian Government is committed to improving the status of Aboriginal people in South Australia through addressing all aspects of life, including health status.

Aboriginal people have continuing rights and responsibilities as custodians of their land associated with traditional ownership and as members of kinship groups and families.

Aboriginal people experience a range of health challenges attributable to the on-going impact of colonisation and to many socio-economic factors.

The historical and contemporary context and conditions, within which Aboriginal South Australians live, including the loss of country, have made it difficult to attain and sustain good health and wellbeing. Widespread social disadvantage and poor physical, spiritual and emotional health impact on many Aboriginal lives. Full or partial exclusion from employment opportunities, poor housing and education, exposure to unacceptable environmental conditions and over-representation in the justice system place Aboriginal South Australians at a much higher risk of social stress and health disadvantage than non-Aboriginal people further compounds the stress experienced, adding to the burden of disease across the community.

Given this context, SA Health will support individual, family and community health and wellbeing initiatives that address the complex interaction of social, cultural, economic and physical environments in which Aboriginal people live.

SA Health will continue to develop and implement strategies to provide health services and models of health care that address the patterns and burden of disease experienced by Aboriginal people as a whole and by particular population groups such as men, women, the elderly, children and young people.

### **Statement of Commitment**

SA Health is responsible for the provision of a range of health services in primary health and acute care settings. The specific needs of Aboriginal people will be met through a comprehensive primary health care approach that addresses physical, mental and social health and wellbeing. The particular needs of Aboriginal people will be addressed in all areas of SA Health's responsibility.

SA Health is committed to improving health outcomes for all Aboriginal people in South Australia, so that differences in health status with the rest of the South Australian population are eliminated.

## Adult Community Mental Health Services for People of Culturally and Linguistically Diverse (CALD) Backgrounds

This document relies on the wealth of federal and state government reports, Charters, policies and frameworks surrounding the needs of CALD communities as cited in the Bibliography.

SA Health and the Mental Health Service recognise the importance of culture and the migration experience of South Australian consumers, carers and families of culturally linguistic and diverse backgrounds. This Model of Care will ensure that at every point of contact services are provided in a culturally and linguistically appropriate manner which is respectful of the cultural, linguistic, religious and spiritual needs or other specific needs of people of CALD backgrounds. In addition, consumers and communities of CALD backgrounds are welcomed as active partners in the planning and development of culturally competent mental health care services.

It is acknowledged that in accessing mental health care services, referrals may come from a variety of sources which may include family or service agencies who work with CALD people, who may have important information about culture and language to assist in improving the pathway of care for individuals.

Open communication is recognised as an essential component of all health care delivery, and service providers at the first point of contact will identify the need for a language service, to establish the extent of English language competency, and to identify the correct language and dialect of fluency, as well as any relevant cultural sensitivities (ie: gender). Such information will immediately be recorded electronically in the individual's Mental Health Care Plan, to ensure that no future delays are created in obtaining relevant information. The use of family members as interpreters is totally inappropriate, although a family member may be invited by the consumer to attend interviews.

A person's cultural values may significantly influence both the process of healing and the effectiveness of interventions. Individuals will vary in the degree and level of acculturation, and their desire to have families involved as part of their healing process.

Wherever and whenever CALD individuals present to mental health services on their individual journey towards recovery, service providers have an obligation to work consistently to improve collaborative partnerships across the spectrum of primary health, general practice, specialist mental health and community mental health services in both government and non-government sectors.

## National Mental Health Standards

NMHS	Title	Descriptor
1	<b>Rights &amp; Responsibilities</b>	The rights and responsibilities of people affected by mental health problems and / or mental illness are upheld by the Mental Health Service and are documented, prominently displayed, applied and promoted throughout all phases of care.
2	<b>Safety</b>	The activities and environment of the Mental Health Service are safe for consumers, carers, families, visitors, staff and its community.
3	<b>Consumer and Carer Participation</b>	Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.
4	<b>Diversity Responsiveness</b>	The Mental Health Service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.
5	<b>Promotion and Prevention</b>	The MHS works in partnership with its community to promote mental health and address prevention of mental health problems and / or mental illness.
6	<b>Consumers</b>	<p>Consumers have the right to comprehensive and integrated mental health care that meets their individual needs and achieves the best possible outcome in terms of their recovery.</p> <p>(Note: The consumer standard is not assessable, as it contains criteria that are all assessable within the other standards.)</p>
7	<b>Carers</b>	The Mental Health Service recognises, respects, values and supports the importance of carers to the wellbeing, treatment, and recovery of people with a mental illness.
8	<b>Governance, Leadership and Management</b>	The Mental Health Service is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.
9	<b>Integration</b>	The Mental Health Service collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

<p><b>10</b></p>	<p><b>Delivery of Care</b></p>	<p><b>10.1 Supporting Recovery</b>  The Mental Health Service incorporates recovery principles and provides consumers with access or referral to a range of support programs aimed at supporting their recovery.</p> <p><b>10.2 Access</b>  The Mental Health Service is accessible to the individual and meets the needs of its community in a timely manner.</p> <p><b>10.3 Entry</b>  The entry process to the Mental Health Service meets the needs of its community and facilitates timeliness of entry and ongoing assessment.</p> <p><b>10.4 Assessment and Review</b>  Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carer(s).</p> <p><b>10.5 Treatment and Support</b>  The Mental Health Service provides access to a range of evidence based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.</p> <p><b>10.6 Exit and Re-Entry</b>  The Mental Health Service assists consumers to exit the service and ensures re-entry according to the consumer's needs.</p> <p><b>10.6.1</b> do not keep the planned follow-up arrangements.</p>
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## Section 1 – Background

### 1.1 Identified Need for Change

The first step in the development of the Adult Community Model of Care was taken in August 2005 when the Premier of South Australia gave a mandate to the SA Social Inclusion Board to review policy and advise on the redesign and improvement of South Australia's mental health system. (*SIB Mental Health Reference – Policy Drivers Discussion Paper, May 25th 2006*).

Social Inclusion Unit Advisory Panels were convened and conducted consultations throughout 2006 with Workforce & Professions, Consumers Carers & Advocates, the Non-Government Sector, Country SA and Aboriginal populations. (*Communiqués from the Panels and the Country and Aboriginal Consultations, May 2006*)

The SIU also undertook national and international research including monitoring of developments around the world that are regarded as cutting edge in the reform of mental health systems. (*Mental Health Reference Background Papers for the Social Inclusion Board; undated, available on SIU website: www.socialinclusion.sa.gov.au*).

The resulting report: “*Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012*” described “a detailed five-year action plan to reform the mental health system in South Australia and to provide better, more responsive services and an integrated system of care” (p viii).

*Stepping Up* (the Report) described “an imbalanced mental health system with pathways that are congested and crisis-driven”, and a linear pathway from admission to treatment to discharge. “Once discharged, consumers have not guaranteed re-entry or ob being ‘recognised’ if they do. Re-entry is usually through a single entry crisis gateway (eg emergency departments in public hospitals) and generally treated as a new episode of illness, not a continuation of the previous episode. The result is that people have to navigate around the system, rather than the system being managed around the people”. (p8)

Section 2 of the Report described a Stepped System of care approach to resolving the complex service system that currently exists, and placed community mental health services at the centre of the system with “responsibility for managing the partnerships with primary health care, private specialists, other government sectors and the non-government sector. Further, that Community mental health services should also have responsibility for all mental health services outside of acute in-patient services and long-term care. This responsibility would include all intermediate care facilities”. (*Appendix 1 - SIB “cog” model – page 34 SIB*)

It was noted that changes to team functions and changes in the way functions are allocated to teams would be required to achieve the vision of community teams at the centre of the system. The functions of Assessment and Crisis Intervention Service, Continuing care, Assertive community treatment (Mobile Assertive Care Teams) were described and it was found that “One of the strongest messages from the consultation was the need to restore multidisciplinary teamwork in mental health teams” once the functional arrangements are clear and agreed upon, and geographic areas are defined. (pages 35-37)

In 2007 in response to the Recommendations emanating from the *Stepping Up* report, SA Health undertook a more detailed review of Community Mental Health Services in South Australia. The review team comprised 12 members drawn from local services and a range of disciplines, led by an external reviewer invited by the Director of Mental Health Operations to facilitate the process. (*A review of Community Mental Health Services in South Australia, January 2008*).

Chapter 6 of that review describes in detail the Current Reality of existing community mental health services in the Greater Adelaide area, which highlighted major inconsistencies of service delivery, models of care, access/entry routes, continuum of service delivery, clinical records and

documentation, multidisciplinary teams, after hours provision of service, models of governance, non-government organisations, performance indicators, and country service links. Chapter 7 identified sixteen (16) principles for reform necessary to address the inconsistency of service delivery and to guide the change process required to achieve the Recommendations described in the *Stepping Up* report. The Review team delivered 22 Recommendations to address these issues.

## 1.2 Outcomes of Reviews

Six (6) new geographic Sectors were announced by the Chief Executive SA Health on October 13, 2008 to “facilitate and improve consumer access and deliver services closer to those in need of care of community mental health services in the Adelaide metropolitan area”. The map of catchment areas and preferred suburban locations for each Community Mental Health Centre (CMHC) together with total and adult population data which was attached to the CE’s announcement is attached here at **Appendix 5**. Sector boundaries are consistent with Regional Health Services and conform to the new whole of Government organisational boundaries.

Each Sector will operate a CMHC as part of an integrated care system, linked to other care facilities across the community to enable and enhance the stepping up and down of care as required by consumers on their journey towards recovery.

A Community Mental Health Reform Project Implementation team commenced work in 2008.

### Alignment

This document is grounded in the SA Mental Health Act (2009), the (draft) SA Mental Health and Wellbeing Policy and the draft of the revised National Standards for Mental Health Services (2008).

The SA Mental Health Act, 2009 was passed by State Parliament on 3 June 2009 and assented to as an Act by the Governor in Executive Council on 11 June 2009. The Mental Health Act 2009 will be proclaimed on 1 July 2010. The new Act underpins mental health reform in South Australia and will provide South Australia with an improved legislative framework that more explicitly articulates the rights of people with mental illness and facilitates, to the greatest extent possible, their recovery and participation in community life. *The Code of Practice for Authorised Health Professionals associated with the SA Mental Health Act 2009 describes and outlines various aspects of the Act.*

This document should also be read in conjunction with the South Australian Mental Health and Wellbeing Policy 2010-2015 (the Policy), which provides the Strategic Context, Background and Vision, Objectives and Principles which have guided the reform and delivery of mental health services in this State. The Policy aligns with the key strategic objective of the SA Health Strategic Plan to reform mental health care in South Australia and Target 2.7 of South Australia’s Strategic Plan to improve psychological wellbeing in South Australia. The Policy is consistent with the directions of the National Mental Health Strategy, including the National Mental Health Policy 2009-2014 and the National Mental Health Plan 2009-2014.

The Policy provides the detail of each of the elements across all areas of Mental Health Care service provision, with clear and identified priorities: Right and responsibilities; Health promotion, prevention and early intervention; Access and integration of services; Specialist mental health services and interventions for high risk groups; Partnerships and inter-agency collaboration; Workforce development and planning for the future; Safety and quality; and Knowledge and information management.

## 1.3 Overview Model of Care

### Objectives

The core objectives of this Model of Care are to:

- improve consumer and carer experiences with community mental health services,
- remove all possible gaps in service provision to consumers and carers,
- improve consumer outcomes
- ensure appropriate and timely access and seamless pathways of care exist for consumers and carers
- implement a recovery-focussed approach to service delivery\*<sup>1</sup>
- ensure the consistent delivery of integrated community mental health services across the metropolitan areas, in six CMHCs located close to where consumers live
- provide consumers, carers and the workforce delivering services to adults aged 18-64 years, living in the Adelaide metropolitan regions with a clear, integrated service model which achieves the changes described as necessary in the reform reviews and recommendations.
- establish stronger partnerships with all primary health care service providers to benefit consumers and carers.

This Adult Community Model of Care is the end result of an extensive collaborative consultation and workshop process with all stakeholders including consumers and carers, government agencies and non-government service providers and reflects both a recognition and acceptance of the need for reform and a commitment to its implementation.

To achieve consistent service delivery across the metropolitan areas, all existing Regional service models will be superseded by this document, and should be removed from circulation in all formats (hard and soft copies) in all locations.

### Scope

The Model describes the service level principles and processes that inform, underpin and direct the provision of community mental health services to adults aged 18-64 years across the two Adelaide metropolitan health regions – Central Northern Adelaide Health Service (CNAHS) and Southern Area Health Service (SAHS).

Each service component of the stepped system of care endorsed by the SA Government is described in a suite of documents which together direct Mental Health Care Service delivery across South Australia. Where a Key Intersection Point occurs with another Model of Care, this is indicated by margin note.

All information pertaining to Care Planning is addressed in the SA Mental Health Care Plan Information Booklet and Mental Health Care Plans which are completed by consumers, carers and clinicians to ensure that the consumer is actively engaged in the process of their care and treatment.

Likewise, all information relating to Assessment is addressed in the Standard Mental Health Assessment and Risk Assessment tool and associated Business Rules, which is the standard for South Australia. The tool has been designed to support clinicians to conduct, record and communicate assessments in a manner which supports best outcomes for clients, carers and clinical teams.

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<sup>1</sup> As described in South Australia's Mental Health and Wellbeing Policy 2010-2015 (p5) & Appendix 3 herein

This document should also be read in conjunction with the Aboriginal Mental Health Impact Statement, and the Framework for the Implementation of the National Health Plan 2003-2008 in Multicultural Australia: National Mental Health Strategy, Commonwealth of Australia (2004).

## **Structure of the Document**

To facilitate clarity, information is presented in sections:

**Section 1 – Background** provides information on why the need for change in South Australia’s mental health system. It discusses the reviews undertaken to initiate this change and their outcomes to support the need for change.

**Section 2 – Service Framework** establishes the social care context for adult community mental health care within the wider sphere of primary mental health care, prevention, health promotion and early intervention, General Practice, private specialists and non-government service providers.

In accordance with SA Health’s ‘*Consumer and Community Participation Policy Directive*’ (August 2009) this document takes Consumer and Carer participation as the primary tenet of service delivery.

*To facilitate consistency of practice and ensure seamless service delivery for consumers and carers, all public mental health services and partner organisations that share key intersection points with this Model will be provided with CMH Consumer Pathway for inclusion in those Models. Consumers, Carers, partners and allied agencies providing services to our consumers will receive an Information Pack outlining the changes to service delivery inherent in this Model of Care.*

Governance arrangements for the six new geographic sectors are outlined, whilst the more detailed description of integrated multidisciplinary team structures, functions and roles are located under the Workforce Section of the Model.

**Ongoing Evaluation** of service delivery, workforce, safety & quality, training and all aspects of this Model of Care, including regular consumer and carer feedback, will be a core function of the Sector Managers, with reporting against KPIs and National Standards.

**Section 3** – This **Model of Care** relies on the Consumer Pathway as the foundation template for service delivery. The Pathway defines the core components of community-based adult mental health care, the key principles and processes attached, and enables the required consumer-focus for service delivery to be met across all six geographic sectors.

Relevant National Standards for Mental Health Services are highlighted in boxed sections at the commencement of each Pathway section.

Workforce elements such as the integrated teams, roles (named Care Co-ordinators, Duty Work arrangements, Walk-in services) and functions are described, alongside Sector management arrangements.

This Section also contains the Core Elements of Aboriginal Mental Health Model of Care as recommended in the *Aboriginal Mental Health Consultation Report (draft, 2008)* to ensure that services to Indigenous people are addressed in a manner and using methods that are respectful of their cultural needs.

**Section 4 – Operational Guidelines** provides the iterative detail of all aspects of the Model, again following the Consumer Pathway which forms the platform for implementation of the Model of Care. Common Business Rules will be developed, agreed and monitored across the two metropolitan regions to ensure implementation of the Model occurs consistently in all six sectors.

## **Consumer Demographics and transition to other services**

Whilst Adults aged 18 to 64 years are the primary focus for Community Mental Health Centres, it is acknowledged that close co-ordination of services across age groups is required as people transition out of one service into another relevant to their requirements. The Consumer Pathway (page 18) provides the common link between other elements of the mental health care system, states the core principles and outlines processes for establishing the required connections with the consumer's allocated Care Co-ordinator.

Adult CMH teams will work collaboratively with regional Child and Adolescent Mental Health Services (CAMHS) for consumers aged 16 to 24 years in recognition of their specialist needs and the importance of a seamless transition with the adult sector as required.

The Early Psychosis Intervention Service model will link seamlessly with both the CAMHS and this Model of Care through a hub-and-spoke service delivery model to ensure that there is a smooth transition for young people experiencing a first episode of psychosis.

Flexibility will be maintained in terms of eligibility for service on the basis of age. Community Mental Health workers will continue to work with consumers presently receiving services who are over 65 years, in partnership and collaboration with teams providing Mental Health Services to Older People.

Given the Social Inclusion Board's placement of Adult Community Mental Health Services (Metropolitan Regions) at the centre of the service delivery system, the full range of Service Models which share Key Intersection Points with Adult Community Services and form the complete stepped care system are:

- Body Image & Eating Disorders (Statewide, hub and spoke)
- Child & Adolescent Mental Health (Northern & Southern)
- Community Recovery Centres (24-hr supported accommodation, rehabilitation-focus)
- Country Health SA (including Rural & Remote) and Limited Treatment Centres established under the 2009 SA Mental Health Act
- Forensics (Statewide service)
- Glenside Re-development: Acute In-patient; Psychiatric Intensive Care; Secure;
- Intermediate Care Centres (bed-based, acute services, country and metro)
- Mental Health Services for Older Persons Future Service Model (draft, v4.0)
- Perinatal and Infant Mental Health (Statewide, hub and spoke)
- Emergency Department and In-patient Units as described in the SA Health Model of Care for Major Hospitals
- Housing and Accommodation Support Partnership program
- Individual Psychosocial Rehabilitation & Support Services (Non-Government Sector)

## Section 2 – Service Framework

### 2.1 Community Mental Health in the Context of Primary Health Care Services

This Model recognises the social care context of adult community mental health care within the wider context of primary mental health care and early intervention. In South Australia consumers access community mental health care through a wide range of service providers including state-wide specialist services (eg Perinatal, Forensic), primary health care teams, General Practitioners, private practitioners and a range of non-government organisations.

### 2.2 Primary Mental Health Care and Early Intervention Principles

Effective health promotion, prevention and early intervention strategies play an important role in improving access to mental health care and the provision of mental health care services. As the first level of contact with the health care system for most people, primary health care services can provide improved opportunities for prevention and detection of mental disorders, as well as treatment and follow-up, including the treatment of developing or existing co-morbid physical conditions. General Practitioners play a vital role in maintaining the on-going physical health of mental health consumers, in conjunction with a range of other service providers, including psychologists, psychiatrists and non-government agencies.

The new role of Care Co-ordinator described herein provides consumers, carers and other involved service providers with a single liaison point to ensure continuity of care exists across the spectrum of providers, in the best interests of meeting consumers' needs.

### Partnerships<sup>2</sup>

The interface point with each service provider represents a critical component in ensuring continuity of care without gaps exists for consumers and their carers who may engage with both private and public sector services, thus the strength of partnerships become a vital link.

General Practitioners have a particular role in the on-going care of mental health consumers. This may be via a direct one-on-one relationship, or it may be delivered by a mental health worker employed by a local Division of General Practice. It is acknowledged that some General Practitioners are able to provide Mental Health Shared Care services, Commonwealth-funded Better Access programs and may also provide access to allied psychological services. Where a consumer is receiving such services through their GP, the information should appropriately be shared with the CMH team, particularly with the Care Co-ordinator, so that a full picture of services and providers is known, and recorded in consumers electronic files.

In order to deliver integrated community-based care, it is anticipated that a very high degree of bilateral partnership processes will drive service delivery at all levels of care. To ensure that the objectives described in this Model are met, and the primary focus on consumer needs are achieved, the function of strengthening partnerships with other service providers is embedded as a key aspect of integrated team members' roles, with higher level accountability for facilitating cross-agency partnerships being a core function of Team and Sector Managers. Given that such partnerships may also be driven externally, it is anticipated that all service providers will participate fully in their shared service delivery role.

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<sup>2</sup> As per SA Mental Health & Wellbeing Policy, Section 6.6

## 2.3 Service Integration<sup>3</sup>

Both the *Stepping Up Report* and the *SA Mental Health & Wellbeing Policy* section 6.3: Access & Integration explicitly describe the need for continuity and integrated care from least to most intensive care services, including supported accommodation, community rehabilitation, intermediate care, acute in-patient care and secure care. The inclusion of the Adult Consumer Pathway provided here into **all other** SA Mental Health Service Models provides a direct mechanism for ensuring that seamless integrated service delivery occurs at each point in the continuum of care, and reinforces standardised expectations for vulnerable consumers who may be moving across the stepped care spectrum.

This Model of Care has integrated the Core Elements of the Aboriginal Mental Health Model of Care as described in the *Aboriginal Mental Health Consultation Report (draft, 2009)* to ensure that services to Indigenous people are addressed in a manner and method respectful of their cultural needs. For CALD consumers, the policy statement at the front of this document and existing regional policies will ensure that their specific cultural needs are recognised and addressed respectfully and consistently.

## 2.4 Service Delivery Principles

SA's Mental Health & Wellbeing Policy 2010-2015 establishes the framework for delivery of all mental health services, and under Section 5 lists eight principles that also guide provision of Adult Community Services. Section 3 of this document describes in detail the guiding principles and processes that govern the delivery of services to adults across the two metropolitan areas.

**“Any door is the right door”** is the core principle enabling consumers and carers to access services at any point in the continuum of care, with the expectation of being treated with respect and concern, and of receiving quality services.

In practice, this means that regardless of where a consumer presents along the care continuum, entry or re-entry to care will be provided, appropriate assessment of needs established, and contact with a consumer's allocated Care Co-ordinator will occur, to ensure that each consumer receives care relevant and appropriate to their need. Where direct access to the level of service required is not immediately available, interim arrangements will be negotiated and implemented to provide continuing treatment and support.

The combination of “open-access” principles of care and integrated multidisciplinary teams operating in six geographic sectors close to consumers, should assist in reducing the number of presentations to hospital Emergency Departments. Regions and Sector Managers will develop policies and common business rules that ensure stronger links are created with hospital EDs and their community mental health teams.

- Consumers' and carers' wellbeing is recognised as the central concern of all workers in mental health care services.
- Each Community Mental Health Centre (CMHC) will provide public clinical mental health services, and psychosocial rehabilitation care funded through NGOs, to people with moderate to severe mental health problems with associated psychiatric disability.
- The Sector CMHC will be the primary location for delivery of integrated services. Some sectors may require secondary (satellite) locations to improve their ability to deliver services.
- Each Sector will operate under identical management structures which reflect the new integrated service delivery model described herein.

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<sup>3</sup> National Mental Health Standard (9)

- Sector Managers and Community Mental Health Teams will oversee the consumer journey, care-co-ordination, care planning and interaction with a range of other service providers to ensure that continuity of care is achieved across the spectrum of consumer needs.
- Each CMHC will provide core services to its catchment population. For services that cannot be provided on a “per sector” basis, a hub and spoke service model will apply which effectively engages local sector staff in the co-ordination of services to best meet consumers’ needs.
- Some specialised services will be provided by partnerships between Sectors or coordinated through state-wide networks. The creation of Sectors will not affect a consumer’s right to access specialist services provided by or located in another Sector.

## 2.5 National Standards for Mental Health Services

Applicable National Standards are noted wherever they apply throughout this document.

The National Standards for Mental Health Services focus on:

- How services are delivered
- Whether they comply with policy directions
- Whether they meet expected standards of communication and consent, and
- Whether they have procedures and practices in place to monitor and govern particular areas – especially those which may be associated with risk to the consumer, or which involve coercive interventions<sup>4</sup>. (NMHS p3/99)

Once enacted, the National Standards will form the basis of National Accreditation for all state and territory mental health services, and will determine the basis on which SA Mental Health Services will be audited to determine their degree of compliance with National Standards.

The NSMHS Consumer Standard is designed to inform consumers about their rights and responsibilities and (describes) the key elements underpinning the provision of quality services that consumers can expect to receive from their mental health service providers throughout the continuum of care. This aspect is not assessable as part of an audit, as it contains criteria that are all assessable within the other standards.

Standards of Care must also meet the nine (9) Key Performance Indicators (KPIs) for Australian Mental Health Services (2005):

Effectiveness, Appropriateness, Efficiency,  
Accessibility, Continuity, Responsiveness,  
Capability, Safety, Sustainability

In the context of this document, Regional Executives and Sector Managers will carry this responsibility.

## 2.6 Safety and Quality

This core component provides a mechanism for monitoring outcomes and reviewing performance against National Safety and Quality Standards, with the aim of achieving the highest possible level of mental health care for South Australians.

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<sup>4</sup> NMHS p2/99



National Safety and Quality Standards will be embedded and operate in each CHMC in line with the SA Mental Health Safety and Quality Framework, currently under development. The Framework will include standardised, evidence-based clinical practice protocols that involve the ongoing, consistent and sustainable protocol training and credentialing of CHMC clinical staff.

These safety and quality principles will operate consistently across all 6 Sectors to ensure valid and reliable data is collected on registered mental health client health status and wellbeing, and to ensure comparable monitoring and evaluation of client health outcomes and continuous quality improvement across all mental health services. Regions will ensure that all CMHC will develop consistent principles and processes to ensure stats are achieved or exceeded and will meet KPI's.

## 2.7 Physical Health and Wellbeing

Physical health is a vital component of general wellbeing, and screening must occur at the point of entry for all consumers coming into the mental health system. Regular physical health screening must occur throughout the consumer's time with mental health services and appropriate follow up must be offered. Community Mental Health Centres will identify and respond to general health risks which are more prevalent in people being treated for mental illness, eg diabetes, obesity, tobacco use.

This aspect of care delivery will require strong partnerships with General Practitioners and other community-based primary health services (see Partnership statement above). Joint responsibility for on-going monitoring of these parameters will be carried by Regional Executives, Sector Managers and the Statewide Metabolic Monitoring Group.

## 2.8 Integration Principles

As identified in the *Stepping Up report*, the practice of dividing services along "Acute" (In-patient) including Crisis Intervention & Assertive Outreach and "Community" including Continuing Care, Rehabilitation & Recovery, works against the principles of seamless service delivery, and the aim of delivering integrated services to those in need. Those functions are described here as an integral part of the continuum of care functions within the Multidisciplinary Team, with the Consumer Pathway providing the driving mechanism for delivering all aspects of care.

The principal integrating mechanisms which will exist within each and across all six Community Mental Health Sectors have been grouped here according to Consumer and Management issues:

### **Consumer-driven Integration Principles:**

- The appointment of a named Care Co-ordinator for each consumer will facilitate the integration of care and provide a single contact point for information for consumers and carers, and for partner organisations who may also be providing care
- The integration of previously separate service components within multidisciplinary teams (crisis, outreach, etc) will ensure that there is no perceptible delay by the consumer or their carer accessing community mental health team support, regardless of their point of entry.
- As specified in *the Policy* document, high risk consumer groups including those with complex needs will be consistently recognised as a "high priority", quickly identified and referred to appropriate team members and where appropriate to non-government providers to meet their multiple care needs.
- All referrals received from external service providers will be responded to promptly to ensure that the consumer receives timely services consistent with their care needs.
- Where a delay is identified before a consumer can receive care, the Care Co-ordinator and Team Manager will ensure that interim services are in place to support the consumer and carer until the required level of care can be accessed, and will continue to provide monitoring of the consumer's needs
- Care Co-ordinators will ensure that no gaps occur in service continuity occur during transfer of a consumer's care between sectors, service elements or between service providers.

**Sector Management Integration Principles:**

- The Consumer Pathway provides the foundation principles and processes for access, entry, assessment (including risk assessment), continuity of care, referrals and transfer of care, and discharge/exit and re-entry to care, which are explicitly described herein.
- Standard documentation will exist across all Sectors for Assessment, Care Planning, *Referral and Discharge Planning*
- Case note information will be shared as appropriate, with consumer and carer consent; a single electronic medical record is the required optimal standard .
- Standardised Care Plans will be produced in accordance with the Mental Health Care Plan Information Booklet and associated care plans which will become mandatory in 2010 (Refer to the SA Mental Health Act 2009, Part 6: Treatment and Care Plans);
- Adherence to National and state mental health standards eg: for clinical review, communication with general practitioners, discharge planning from inpatient to community.
- Within Sectors, management of community-based residential units, ICCs, CRCs and SRFs will retain their own staff, policies and procedures, but will be closely linked to community-based professional staff and will utilise the Principles and Processes described in the Consumer Pathway to ensure that integrated service delivery for consumers and carers is achieved.
- Clear, regionally-consistent, service-wide communications protocols will enable staff members to communicate directly with their colleagues in other Sectors
- Standardised computer systems will enable immediate transfer of key documents (including case notes, Care Plans and relevant reports) between Sectors

## Section 3 – Model of Care Components

### 3.1 Governance

NSMHS 8: Governance Leadership and Management: The MHS is governed led and managed effectively and efficiently to facilitate the delivery of quality & co-ordinated services.

The Regional Executive Director of Mental Health Services in each metropolitan region has overall responsibility and accountability for the access/entry, treatment/care, referral/transfer and discharge/re-entry of consumers of Adult Community Mental Health Services, regardless of their clinical status, stage of illness and locus of treatment (in-patient / bed-based services, community-based treatment and recovery-oriented rehabilitation services, and supported accommodation).

Services will be provided through 6 geographically-based Sectors across the two metropolitan Regions, each with a Sector Manager with line reporting responsibility for all management and workforce issues. Within Sectors, a number of multidisciplinary teams will provide services to the local population. Each Multidisciplinary Team will have a Team Manager, and a Sector-wide Clinical Co-ordinator.

Adult Community Mental Health Services will operate in a manner consistent with the Principles described below, in accordance with the Mental Health Act (2009), with SA Health state-wide and regional policies and procedures, and in accordance with draft revised National Standards for Mental Health Services (2008).

### 3.2 Principles and Processes

The Model of Care principles reflect a Policy commitment to putting consumers and carers needs at the forefront of service delivery. The information contained in this section was developed through extensive consultation with consumer and carer representatives, with staff from the spectrum of community mental health services, including non-government organisations.

#### Objective

The Principles and processes contained in this section will enable Regional Executives, Sector Managers, Team Managers and Community Mental health team members to ensure that there is consistency across all aspects of the consumer experience, resulting in seamless service provision to consumers and carers wherever they enter the community mental health service system.

All service provision will be guided by safety and quality considerations and performance and outcome monitoring will be an integral component of all aspects of service delivery.

#### Core Principles

- All entry points, referrals, transfers, discharge/exit and re-entry processes to adult community mental health services will be clearly identified and made available in printed format to consumers and carers.
- Service providers at all points of the care continuum will respect consumer and carer choices.
- Each consumer will have a named contact person allocated following first assessment. This person will be the designated care coordinator.
- Where a consumer has high and complex needs as evidenced by either clinical condition and/or co-morbidities and/or their involvement with multiple external agencies, they will be allocated a Case Manager, who may also be their Care Co-ordinator.

- Integrated Multidisciplinary Team structures will be replicated across the six geographic sectors in metropolitan Adelaide to enable consistency of practice and the delivery of seamless services to consumers. These teams will provide a full range of core services. There may be minor variations depending on context and/or skill mix of team members.
- All Mental Health Services will use standardised documentation for clinical and risk assessment, Care Planning, Referral and Discharge/Exit. Compliance with ICT Clinical Business Rules will guide seamless consumer transitions across service components.
- **Priority approach for Consumers with High and Complex Needs**  
As described in the *Policy* document, and in accordance with the Recommendations in the *Stepping Up* report, this cohort is recognised as a high priority for service response, wherever they present in the care continuum. The comprehensive needs of such individuals will be addressed by comprehensive assessment of their clinical and other agency needs, and through collaborative care planning, monitoring and case conferencing with a range of agencies. Such individuals may require the highest level of care co-ordination available.

### 3.3 Consumer Pathway

The Consumer Pathway will be clear and explicit to all consumers, carers and the mental health workforce, and will contain the five components which are described below in terms of their Operational implementation:

- Access - Entry
- Assessment & Review
- Continuity of Care/Treatment & Support
- Transfer – Referral
- Discharge/Exit - Re-Entry

A copy of the Consumer Pathway will be provided to all consumers, carers and the mental health workforce.

## Diagram : Consumer Pathway

Pathway	Principle	Processes
<b>ACCESS</b>	<i>Any door is the right door Consumers will always receive Good Service</i>	<ul style="list-style-type: none"> <li>Consumer &amp; carer are provided with contact name &amp; number</li> <li>Recognition of consumers and carers as our central concern</li> </ul>
<b>ENTRY</b>	<i>No barriers to entry</i>	<ul style="list-style-type: none"> <li>Triage processes are in place</li> <li>All Triage Services are aware of &amp; implement new MoC principles, pathways &amp; processes</li> <li>Consumer Data is entered on IT system immediately</li> </ul>
<b>ASSESSMENT</b>	Core skill for all MH workers	<ul style="list-style-type: none"> <li>Consumer &amp; carer are provided with contact name &amp; number</li> <li>Use SA Standard MH Assessment &amp; Risk Assessment document ("standard Assessment document") which includes Physical Health assessment</li> <li>Data is entered on IT system immediately All Treatment/care needs are established</li> <li>Standard Care Plan is developed in consultation with consumer &amp; carer</li> <li>Care Co-ordinator / Case Manager is appointed as per consumer &amp; carer needs &amp; degree of complexity (ie: multiple agencies involved)</li> <li>Contact details for CC/CM are entered on IT system immediately</li> </ul>
<b>CONTINUITY OF CARE</b>	<i>Always act in consultation with consumer &amp; carer  Always be responsive to consumer &amp; carer requests for variation in level of care</i>	<ul style="list-style-type: none"> <li>Regular/scheduled review of Care Plan with Consumer &amp; Carer</li> <li>Regular/scheduled re-assessment is conducted with Consumer &amp; Carer</li> <li>Data is entered on IT system immediately Overview by Care Co-ordinator / Case Manager – advised of any changes</li> </ul>
<b>INTERNAL MHS TRANSFER</b>  OUT OF CMHC (eg INTO BED-BASED CARE, OR TO NGO)	<i>Transfers to bed-based care or NGO provider do NOT constitute discharge from CMHC  Electronic Records follow consumer (No retelling history)  Always be responsive to consumer &amp; carer requests for variation in level of care  Always act in consultation with consumer &amp; carer  No barriers to re-entry and No direction to re-enter via Triage</i>	<p>Example: Step-up care episode requires transfer to bed-based services, or most services are provided by an NGO</p> <ul style="list-style-type: none"> <li>Decision to transfer care made is in consultation with consumer &amp; carer</li> <li>Care Co-ordination remains in place at <u>all</u> points of pathway</li> <li>Data is entered on IT system immediately Update Care Plan</li> <li>Provide consumer &amp; carer with contact name and number at new care location</li> <li>Advise Care Co-ordinator/Case Manager of any change in level of care</li> <li>When episode settled, consumer returns to CMHC and enters at "Continuity of Care" point in pathway (<u>NOT</u> via Triage)</li> <li>Advise Care Co-ordinator/Case Manager of any change in level of care</li> <li>Full and proper handover occurs, with both parties named &amp; signed; data entered into electronic record within 24 hours</li> </ul>
<b>DISCHARGE - EXIT</b> TRANSFER TO AN EXTERNAL CARE PROVIDER eg: GP, NGO	<i>Electronic Records follow consumer (No retelling history)  Always act in consultation with consumer &amp; carer  No discharge into homelessness</i>	<ul style="list-style-type: none"> <li>Decision is made in consultation with consumer &amp; carer</li> <li>Standard Discharge Plan is completed (to be developed) with copy to consumer/carer and to new provider</li> <li>Utilise Standard Referral form (to be developed)</li> <li>Data is entered on IT system immediately Consumer &amp; carer are provided with contact name &amp; number</li> <li>Consumer records demonstrate/indicate housing/accommodation arrangements and duration in place at time of external transfer</li> </ul>
<b>RE-ENTRY</b>  TRANSFER <u>IN</u> TO CHMC - ENTER AT CONTINUITY OF CARE	<i>NO barriers to re-entry and No direction to re-enter via Triage  Electronic Records follow consumer (No retelling history)  Always be responsive to consumer &amp; carer requests for variation in level of care</i>	<p>Examples: after an absence of several months, recurrence of symptoms, early warning signs or return from bed-based care</p> <ul style="list-style-type: none"> <li>Assessment conducted</li> <li>Use standard Assessment document</li> <li>Data is entered on IT system immediately Revised Treatment/care needs are established</li> <li>Revised Standard Care Plan is developed in consultation with consumer &amp; carer</li> <li>Care Co-ordinator / Case Manager is advised of re-entry</li> </ul>

## **Access – Entry**

### **Guiding Principle – “Any door is the right door”**

“Any door is the right door” is the governing principle of all Community mental health services. As stated in the *Policy* document, the SA Mental Health service philosophy is to provide access to the best possible mental health care to all consumers, and to deliver proactive, timely intervention and continuing care with the aim of preventing or reducing the likelihood of crises arising.

A “Right time, right place, right care” recovery-oriented philosophy will recognise multiple entry points along the care pathway and transparent accessibility will provide consumers, their carers and families with responsive, appropriate care.

Consumers and carers who present at any point of the care continuum will be received and their needs acted upon promptly and appropriately. At any new point of contact, consumers and carers will be provided with a contact name and number, and the details of their contact recorded in their electronic record.

Access points will include but are not limited to:

#### **Telephone**

- During business hours telephone calls to the local Sector CMHC published contact number will be responded to promptly, will not be answered by a recorded message, and will not be allowed to ring out unanswered.
- Each consumer and their carer will be provided with the allocated Care Co-ordinator’s contact details and contact numbers for assistance if required after hours, including the Mental Health Triage Service telephone number.
- After-hours telephone calls to the Sector CMHC published contact number will generate a message containing directions to call the Mental Health Triage Service telephone number for those seeking urgent assistance or assessment.
- Non-urgent telephone calls to Mental Health Triage Service from consumers, carers or other health workers eg. General Practitioners seeking advice or assistance will be provided with the published telephone contact number of each Sector CMHC for action within normal business hours.

#### **Walk In**

- Each Sector CMHC will have the physical and staffing capacity to receive Walk In clients. This may be for requests for information or for clinical services. This aspect of service provision is a critical component of new facility design, and is contingent upon relocation into purpose-built facilities, with due consideration of all safety requirements.
- Each Sector CMHC will have documented policies for administrative and clinical responses to enable safe management of this aspect of service provision.
- This function will be closely allied with the Duty Worker functions described under “Integrated Teams”.

## **Entry - Guiding Principles**

NSMHS 10.3: The entry process to the MHS meets the needs of its community and facilitates timeliness of entry and ongoing assessment

Service providers at all points of the care continuum will accept relevant information that may come from someone other than the consumer and will utilise this information appropriately

All Entry Points will have Business Rules in place to ensure that:

- Consumers and carers are provided with a contact name and number for follow-up contact and details are entered into the consumers' electronic record immediately.
- The person taking first point of contact details enters these on the IT system.
- Creation of a new electronic client record occurs within 24 hours of presentation.
- A named Care Co-ordinator is appointed within 24 hours to assist new consumers and carers to navigate the community mental health system.
- Consumers and/or carers seeking access to services or assistance are provided with clear information in an accessible location.
- Information packages are provided to all consumers and carers, with local contact details and how to obtain emergency assistance outside normal hours of operation.
- Care Pathways are clearly explained to all consumers and carers.
- The specific cultural needs of Aboriginal consumers are addressed, as described in the Core components of the Aboriginal Model of Care.
- Consumers with English as a second language are offered access to written information in the language of their choice wherever possible.
- Community Mental Health Team members will provide non-discriminatory equity of access to people of all cultures and ensure prompt, rapid accessibility to interpreters where required, acknowledging assistance from community and /or family members as valid & useful but recognising that it is not recommended that family members be used as interpreters.

## **Assessment and Review - Guiding Principles**

NSMHS 10.4 – Assessment & Review: Consumers receive a comprehensive, timely & accurate assessment and a regular review of progress is provided to the consumer and their carer(s).

Detailed information relating to the conduct and content of Assessments is contained in the Standard Mental Health Assessment and Risk Assessment tool and associated Business Rules produced by the SA Mental Health Unit. The tool has been designed to support clinicians to conduct record and communicate assessments in a manner which supports best outcomes for clients, carers and clinical teams.

Consumers and carers should receive education about lifestyle, and links to appropriate groups or services and physical health monitoring, focusing on areas of known high risk to people with a mental illness. Interventions should focus on assisting the consumer to make choices regarding their own physical health and wellbeing. Where necessary, close partnerships should exist with the consumer's GP and other workers (e.g. practice based nursing and allied health professionals) involved in supporting the consumer's physical health.

- Preliminary Triage screening protocols determine the degree of urgency for full assessment.
- Face to face assessment will be either immediate or commenced within 24 hours of presentation.

- Where face to face assessment determines that a different level of care is required that will entail a waiting period for access to the prescribed level of care, CMHC Sector and Team Managers will ensure that interim support services are in place.

CMH Team members will ensure that:

- A safe location is available for a consumer to be assessed. This encompasses both physical safety for all participants, respect for dignity of the consumer and attention to privacy and confidentiality.
- Face to face assessment is conducted promptly to determine the consumer's and carer's immediate and longer term needs and goals, recognising that this may require collateral history from family.
- The standard Assessment Tool is used for all consumer assessments, and data is entered into the electronic record within 24 hours, and all components are completed.
- The physical health and wellbeing components of the standard Assessment tool are completed as soon as practicable and are routinely monitored by Care Co-ordinators.
- Care planning commences at the time of face to face assessment.
- Assessment findings are reported to and discussed with the consumer's GP within 48 hours.
- The principle of least restrictive form of treatment and care must be followed according to clinical indications.
- Outreach follow-up is provided if indicated.

### **Care Planning - Guiding Principles**

As a matter of Policy, each consumer and their carer will be directly involved in planning their own care, in accordance with the *SA Mental Health Care Plan Information Booklet* and associated Care Plan documents.

The Care Plan remains with and travels with the consumer and the carer. It will be easily available and will apply across all components of the Mental Health Care service system. The Care Plan will be regularly updated with the consumer and carer to reflect the consumer's strengths, needs and goals. The Care Plan is to be used as a statement of current interventions.

Information about treatment choices will be provided to consumers and carers in a clear and understandable manner.

### **Continuity of Care/ Treatment and Support - Guiding Principles**

- "Records will follow consumer throughout mental health services" is a core principle. To achieve this a single IT system is required across all mental health services regardless of location, level of care and specialty.
- No re-entry barriers or "exclusion" criteria will be used to deny or delay consumers' access to services along clinical, functional, sector or any other lines.



- Sharing provision of care with an external (GP, NGO) provider does not constitute “exit” from community mental health services. Regular scheduled 3-monthly reviews will be conducted, with automatic right of re-entry deemed to exist.

### **Processes**

CMH Teams in all Sectors will deliver regionally and locally consistent services and continuity of care for consumers and carers by:

- Working as an integrated multi-disciplinary team to meet all consumers’ needs and considering social inclusion as a marker of wellbeing.
- Ensuring that Case Management occurs as a priority for consumers with high & complex needs.
- Ensuring that standard assessment and care plan documentation is completed promptly and updated in the electronic record when any change occurs.
- Ensuring that no unnecessary re-assessment or story re-telling occurs, by promptly entering data into the electronic record.
- Ensuring that consumers’ access to external services are consistently and seamlessly implemented (eg through case allocation at team meetings and/or case conferencing; liaison with General Practitioners etc).
- Assertively advocating for consumers and carers needs with other service providers where necessary.
- Ensuring that consumers who require ‘step-up’ services receive such care promptly, but if a wait for access to that level of service is unavoidable, ensures that interim higher level support services are in place.
- Removing any existing barriers to communications and implement seamless communications protocols within CMH services

### **Referrals - Guiding Principles**

In recognition of the reviews findings that previous referral processes created unnecessary delays for consumers, Referrals will now **only** be required when entering or exiting Community Mental Health Services, eg to external providers. No referral is required between team members for services that are managed within the Sector.

- A standard referral process/format available on CBIS will facilitate the activation and tracking of referrals.
- Allocated Care Co-ordinators will carry responsibility for ensuring that any referrals are followed through to completion, and that a full and proper handover is conducted.
- Mental Health clinicians, Care Co-ordinators and Case Managers may generate referrals to external health service providers, other government and non-government agencies

### **Processes**

#### **Incoming Referrals**

For example from General Practitioners, other external health professionals or non-government agencies, will be managed according to principles and protocols consistent with Entry (see above).

**Outgoing** - eg where a consumer's care is transferred to another service provider (see also Transfer of Care, below).

- Consumers and carers are always involved in decisions to transfer care to another provider within SA mental health services and NO formal Referral processes are required – proceed as per Transfer of Care (details below).
- Care Co-ordination remains in place at all points of the pathway
- Electronic files are current and records follow consumer
- Care Co-ordinator (if not the primary therapist) is advised of any change in the level of care as soon as possible, and at the latest within 24 hours of transfer.
- The consumer and carer will be provided with a contact name and number at the receiving service as soon as possible.
- If a DTO/CTO is in place and a transfer to a bed-based service is the treatment option indicated, transfers may be made without the need for informed consent.

### **Transfer of Care – Definition**

Transfer of Care occurs when a consumer's care is transferred from the CMH Team to another Sector, to another service provider, or to a bed-based service.

The Transfer of Care may be temporary, and the Care Co-ordinator remains involved although if a long-term transfer (eg change of address) is involved, another Care Co-ordinator will be appointed by the receiving service.

For each Transfer, a full and proper handover must take place, with names of transferring and receiving parties clearly indicated in electronic record.

### **Transfers - Guiding Principles**

- Every decision to transfer care is made in consultation with the consumer and carer/family whenever possible.
- The consumer's CMHC Care Co-ordinator is kept informed about changes in the consumer's care at all points of the pathway.
- Transfers to bed-based care, General Practitioner or NGO providers do not constitute discharge from CMHC services.
- Whenever transfers occur, they must be supported by a full and proper handover in writing and entered into the electronic record.
- When a consumer is transferred to bed-based care, all records will be updated on the IT system and electronic records will follow consumer to ensure that no retelling of history is required.
- Consumer (and carer) Care Plans will travel with the consumer to ensure recipient clinicians are informed about consumer preferences.

- As consumer advocates, CMH Team members will respect and listen to expressed concerns of consumers & carers, and will act promptly to assess requests for variation in level of care.
- No transferred consumers will be directed to re-enter mental health services via Triage, unless it is an unavoidable after-hours crisis situation. When this occurs, the consumer's Care Co-ordinator will be advised by telephone as soon as possible, and by immediate entry of relevant data into the consumer's electronic record.

### **Transfer Processes**

- Any changes concerning the consumer's care, treatment or location of treatment should be entered into the consumer's care plan, entered on the IT system, and the consumer's Care Co-ordinator advised within 24 hours
- Consumer and carers must be provided with a contact name and number at the new location of care as soon as possible, and at the latest within 24 hours of a transfer occurring.
- Where clinical assessment demonstrates a need for higher level of services requiring transfer, but a delay in accessing that level of service is unavoidable, the CMH Team must ensure that higher levels of supportive care is in place in the interim. This information should be fully documented in the electronic record, and the Care Co-ordinator advised immediately.
- When an acute phase of illness settles and the consumer returns to community-based care, they will re-enter CMHS at the "Continuity of Care" point on the pathway. They will not be re-directed to re-enter via Triage and they will not be excluded from accessing mental health services by any criteria.
- Where referral is required to services outside CMHS (eg to primary health care service providers, General Practitioners, private psychiatric care, or non-government organisations), a standard referral form will be used, and the data entered in the electronic record.
- Information concerning the Transfer of consumers to whom Treatment and Detention Orders apply is contained within the Mental Health Act 2009 (Division 5, S35)

### **Discharge/Exit – Re-Entry**

NSMHS 10.6 "Exit and Re-Entry": especially "Development of Exit Plans" [p75 in draft document] and NMHS Glossary

### **Definition of Discharge**

Resolution of current health problem is achieved and no further mental health service intervention is required at this time, as agreed between the consumer and carer and the CMH Team.

### **Discharge/Exit - Guiding Principles**

- No consumer will be discharged from CMH Services into homelessness.
- CMH Team members will respect the Consumers choice to decline services, within their clinically assessed capacity to do so (informed consent). Alternatives and options will be discussed with the consumer, carer and family.

## Discharge/Exit – Processes

- Agreement of the clinical judgement of the CMH Team, with input from consumer and carer, is required to collaboratively decide to Discharge a consumer from active mental health services.
- Once a discharge/exit plan has been implemented, the electronic record will show “Inactive” status. However, if or when further treatment is required, the consumer, their carer or family, GP or primary health care provider may request re-entry, **without** the consumer being directed to re-enter via Triage.
- The consumer and carer/family must be involved in Discharge care planning in collaboration with the CMH Team, and with input from General Practitioner or other primary health care provider.
- CMH Team members managing discharge processes must ensure that consumers and carers receive a copy of the discharge plan, that they are advised of and understand the re-entry pathway, and are provided with clear contact details for re-entry if and when required.
- A copy of the consumer’s Discharge/Exit Plan must be included with the letter to General Practitioner and any other service providers. The Care Co-ordinator must be informed and data entered promptly on system.
- If an NGO package is part of the discharge/exit process, CMH Team members must ensure that it is in place with the receiving agency, and that all participants are aware of and understand the details, and that a contact name and number is provided to the consumer.
- Where voluntary consumers show recurrent “Did Not Attend” notes for appointments, and the CMH team or Care Co-ordinator is unable to contact either the consumer or a nominated care/family member, the case will be presented to a full team meeting for a decision as to further action or a decision, cognisant of risk assessment, to mark the file as “Inactive”. A consumer that subsequently returns to community mental health service will re-enter the system by re-activating the file and advising the named Care Co-ordinator.

## Re-Entry - Guiding Principles

No consumer receiving services from a CMHC will be re-directed to re-enter the service system via Mental Health Triage Service unless there is an urgent need for assessment outside of normal working hours.

No barriers to re-entry or exclusion criteria will exist to prevent a consumer from re-entering the service system at any point of the care pathway.

## 3.4 Aboriginal Mental Health

The following core elements of Aboriginal Mental Health care will be implemented in each Sector to ensure that services to Indigenous people are addressed in a manner and using methods that are respectful of their cultural needs.

**Getting in through the door: Engaging in care**

Identifying opportunities for improving engagement can be fostered and enhanced at several levels, particularly those related to working closely with Aboriginal Health Workers, and providing culturally responsive and assertive services at first presentation. One example is ensuring that referrals for Aboriginal people are followed up within 24 hours and seen face-face within 48 hours.

**Ongoing engagement: Remaining in care**

Aboriginal people have clearly articulated they wish to have choice about involvement of Aboriginal service supports or mainstream services, which may change during care. Ensure that choices for Aboriginal worker and service involvement are offered throughout the provision of care and treatment, which is a key factor in Aboriginal people remaining in care. Ensure there are processes in place for the involvement of Aboriginal workers, advocates or family spokespeople, going with the immediate identified need and providing practical support regarding social and family difficulties, which are also important considerations.

**Geographical boundaries: Transfer of care**

Communities have acknowledged that the itinerant nature of many Aboriginal people creates significant issues for continuity of medical treatment and mental health care. However, for many people this may also have a cultural healing component in re-connecting them back to important family and community members, culture and country, particularly following an inpatient stay away from their community. Managing itinerancy requires flexible boundaries, assertive follow-up and significant communication and goodwill between services.

**Going to the people: Community care**

Attending hospital and community mental health facilities often creates excessive anxiety, agitation and emotional distress for many people, so they do not access services or choose to remain engaged in care. Provide environments or services where people feel comfortable such as in the home or local community venues.

**Working with families: Holistic care**

Including family in care is central. A core value of Aboriginal people is the relationships they have with others. This central understanding of the importance of relationships and family has a complex system of responsibility and avoidance, even within more westernised cultures and a broader understanding is required of what this responsibility means in the care and protection of relatives and extended family.

**Ngangkaris and cultural healing: Traditional care**

Connecting people with family, community, culture and country promotes a sense of self and community value and provides opportunities for strengthening the family and the community. For this to be effective, families and communities require practical support and the provision of resources, without which interventions may be or become counter-productive. Valuing, respecting and utilising cultural and traditional ways of healing in partnership with mainstream and other therapies is supported.

**The Patient Journey: Consistent, Planned care**

Specifically, improving the collaborative partnerships, communication and working relationship between Aboriginal Health services and workers, mainstream mental health services and General Practice and Primary Health Care through consistent policy, procedures and targeted programs is essential. Clarifying roles and responsibilities for case management of the illness and emotional wellbeing, management of lifestyle issues and re-integration back into families and communities is required.

### 3.5 Workforce

The *SA Mental Health & Wellbeing Policy* states that a sustainable mental health care system depends on the knowledge, skills and commitment of those responsible for delivering services, and the importance of acknowledging the link between the overall wellbeing and skills of the mental health care workforce and the wellbeing of consumers of mental health care services.

Three key priorities are identified as:

- Recognition and support of mental health workers
- Training and development of staff
- Recruitment and retention of staff

Further, the Policy acknowledges the importance of mental health literacy and skills of workforces in non-health sectors who engage with people with mental health problems, and the need to enhance their skills to more effectively provide services to consumers with mental health needs.

This Adult Community Mental Health Model of Care recognises and endorses consumers' fundamental needs for a culturally-competent, respectful and accessible workforce which will support them to learn more about themselves and focus on them being the expert in their care.

Workforce policies and protocols must preserve this capacity, to enable its growth and to sustain a level of service that is capable of meeting consumer and carer expectations. The following factors are important considerations in achieving this:

- Community Mental Health teams will contain a mix of professional disciplines, skills and qualifications, which, along with clinical leadership and teamwork, are key elements which assist in determining successful consumer outcomes.
- Community Mental Health teams will maintain a balance of Psychiatry, Nursing, Social Work, Psychology and Occupational Therapy members.
- Peer and carer specialist workers will be included as an integral part of the multi-disciplinary team.
- Aboriginal and Indigenous consumers' needs for culturally-competent and respectful assessment and treatment will be met by an appropriately trained workforce across all aspects of service delivery as a core component of this and all SA Mental Health Models of Care, as described above.
- Aboriginal mental health workers in all service settings will be respected for their personal, cultural and professional knowledge, experience and expertise in the delivery of mental health services to their people.

#### **Integrated Multidisciplinary Teams**

An integrated team is one where there is a shared responsibility for the provision of a range of clinical services to a population. The range of recovery-focused functions will include emergency assessment, crisis intervention, assertive care and continuing care as required for individual consumers. The team will provide psychiatric treatment, psychological therapies and other interventions.

Consumers will be able to move between different functions of the team as their need for types of service changes. This will not entail a referral process to move within the Community Mental Health team.

The members of the team will have a range of skills and experience. Some will prefer to work in their area of particular skill and experience and some will prefer to have a mix of clinical work. Most staff will have shared generic skills in eg: clinical assessment, risk assessment and care planning. However the delivery of a particular intervention may be a specialised skill.

For example, a nurse or registrar may have a combination of acute assessment and assertive follow up with some days per week engaged in continuing care. This mix of functions is preferred by some clinicians and the acute aspect of their work is by regular roster. Another example would be a psychologist working as a DBT therapist who would also be the duty crisis worker on some days or would provide psychological assessments at other times.

This degree of flexibility enables skill development and maintenance and also enables a mix of responsibilities that broaden skill base and reduce professional burnout. Staff should have the opportunity to choose their preference and, by negotiation, move within the team if they wish. The degree of choice available will be limited by the overall level of service demand and the matching of staff skill, expertise and capacity with service needs.

Each Sector Multi-disciplinary Team (MDT) should include:

- Administrative support staff
- Clinical Co-ordinator
- Cultural workers (all staff should be fully trained in cultural competency)
- Nursing staff
- Occupational therapists
- Peer support workers
- Psychiatrists
- Psychologists
- Registrars and trainees from all disciplines
- Senior medical officers
- Social workers
- Team Manager

This group of professionals work together to combine a wide range of skills to meet the diverse needs of the consumer group.

All members of the team are expected to fulfil the functions of Care Co-ordinator for a designated part of the consumer group.

Each team should have access to a consumer and a carer advisor, a quality and risk advisor, a trainer/educator, a clinical director, a locality manager, and professional leads or seniors.

This provision of skill mix produces the opportunity for cross-fertilisation of ideas and broadening experience. It provides team support for all participants. They may share information and work interdependently.

### **Dispute Resolution**

The Sector Manager, Team Manager and Psychiatrist/Clinical lead comprise the senior management group within Community Mental Health Sectors. This senior management group will co-ordinate dispute resolution in the event of a dispute not being able to be resolved at a local team level.

## Care Co-ordinator

NSMHS Standard 9 - Integration - states that the MHS ensures that a person responsible for the coordination of care is available to facilitate coordinated and integrated services throughout all stages of care for consumers and carers

In the context of Adult Community MHS for the Adelaide metropolitan region, that person is the Care Co-ordinator. In some services this role is currently called a Care Co-ordinator (or a case manager) but these terms also sometimes imply other or additional functions as well. Hence the term Care Co-ordinator is the preferred term for this function. This person should remain constant as far as possible during an episode of care but during periods of staff leave or other absence the team will ensure a nominated other is available, that a full and proper handover takes place and that the consumer and carer are advised of the name of the interim care co-ordinator.

The Care Co-ordinator has a broker or navigator function and ensures that the consumer's assessment and care plan is completed collaboratively, and that appropriate interventions and services are arranged. In some situations the Care Co-ordinator may also deliver those services or interventions but this is not necessarily so.

The Care Co-ordinator might at times be the person who had first contact if this is appropriate but this will be confirmed at the first meeting of the MDT after referral or after face to face assessment.

Allocation of a consumer to a Care Co-ordinator will be determined by the Team Manager in consultation with the team members, based on current case load and capacity, or by suitability for some other reason

### Core role of the Care Co-ordinator

- Co-ordinate, broker and oversee provision of multidisciplinary (MDT) care plan to consumer and carer.
- Complexity of the care co-ordination role is determined by consumer needs, number of professionals and or agencies involved;
- Being the point of contact for the identified consumer, their families and carers, colleagues, other teams and agencies involved in their care
- Provide clinical input

### Core tasks include:

- Engaging and working in partnership – ensuring the consumer has a current care plan in place
- Contributing to and co-ordinating on-going assessment, monitoring and review
- Support consumer and family/carer core needs, interventions, goals/anticipated outcomes and review process
- Liaise with multidisciplinary team colleagues, cultural advisors, other teams, services, agencies and engaging/brokering their involvement
- Communicate regularly with consumer and family/carer – act as contact point
- Ensure clinical documentation is up to date and plans are reviewed and communicated including any Mental Health Act requirements

### Case Management

- Consumers with high & complex needs who are involved with multiple agencies will be allocated a Case Manager who may also be their Care Co-ordinator



## Team Manager

Team Managers have overall responsibility for managing their multidisciplinary team providing adult community mental health services in their Sector. The number of teams per sector will be determined with Sector Managers according to local combinations of available staff, the number of consumers accessing services and achieving a balanced caseload distribution. Team Managers also carry responsibility for developing and strengthening partnerships with Sector agencies, non-government service providers, General Practitioners, private specialists and others who may interact with the consumer population.

Functions of this role are:

### Team Management

- Act as a key support person to all team members, including Care Co-ordinators, Case Managers and Clinical Leads
- Manage case workload demand and supply issues, and the levelling of clinical workloads
- Ensures all team members, particularly new arrivals, receive an induction to the principles, practices & protocols specified in the Model of Care;
- In conjunction with the Sector Managers, ensures that all staff have the skill sets and experience required to competently assess people at all points of the care pathway, whether they are entering the system in acute distress, or are walk-in consumers or carers
- Carries responsibility for ensuring that the team meets published KPIs
- Chairs multidisciplinary team meetings re intake, clinical review, and transfer of consumers
- Ensures all team members are aware of and implement Safe Practice procedures
- Meets on a regular basis with other Team Managers and the Sector Manager, to achieve consistency of service provision
- Has dual accountability with Sector Manager for meeting all Safety & Quality standards within Team
- Participates with Sector Manager in on-going Performance Development Reviews of Team members
- Maintain and ensures each Team members is aware of and applies all relevant SA Health Policies, Practices & Protocols

Team Manager Functions based on pathway components.

In consultation with team members and Care Co-ordinators ensures that the principles, practices and protocols described in the Model of care are in place and being implemented.

### Access

- Ensures that each consumer is allocated to a team and to a Care Co-ordinator, and that consumers, carers/family receive all relevant information, including local contact details, re-entry processes and how to access services in an emergency.
- Ensures that all data is entered to IT system within designated timeframes

### Continuity of Care

- Ensures consumer and carer participation occurs in assessment and care planning
- Ensures consumer's care plans and regular reviews take place as required
- Ensures NOCC scales and any other measurements are undertaken by all team members at required frequency according to consumer needs
- Oversight of workers' caseloads to ensure that even distribution of workload is occurring
- Ensures that no gaps in service are developing for consumers
- Ensures that all data is entered to IT system within designated timeframes

Referrals / Transfer – In consultation with team members and Care Co-ordinators:

- Ensures that Principles, practices and protocols described in the Model of care are occurring

- Ensures that all Quality & Safety issues are being addressed

#### Discharge/Exit – Re-Entry

- Ensures that agreement of the clinical judgement of the CMH Team, with input from consumer and carer, has occurred when a collaborative decision is made to Discharge a consumer from active mental health services.
- Ensures that once a discharge/exit plan has been implemented, the electronic record will be changed to show “Inactive” status. However, if or when further treatment is required, the consumer, their carer or family, GP or primary health care provider may request re-entry, **without** the consumer being directed to re-enter via Triage.
- Ensures that the consumer and carer/family have been involved in Discharge care planning in collaboration with the CMH Team, and with input from General Practitioner or other primary health care provider.
- Ensures that CMH Team members managing discharge processes have ensured that consumers and carers receive a copy of the discharge plan, that they are advised of and understand the re-entry pathway, and are provided with clear contact details for re-entry if and when required.
- Ensures that a copy of the consumer’s Discharge/Exit Plan is included with the letter to General Practitioner and any other service providers. The Care Co-ordinator is informed and data entered promptly on system.
- Ensures that if an NGO package is part of the discharge/exit process, CMH Team members ensure that it is in place with the receiving agency, and that all participants are aware of and understand the details, and that a contact name and number is provided to the consumer.
- Ensures that where voluntary consumers show recurrent “Did Not Attend” notes for appointments, and the CMH team or Care Co-ordinator is unable to contact either the consumer or a nominated care/family member, the case is presented to a full team meeting for a decision as to further action or a decision, cognisant of risk assessment, to mark the file as “Inactive”. A consumer that subsequently returns to community mental health service will re-enter the system by re-activating the file and advising the named Care Co-ordinator.

#### **Sector Manager**

- Responsible and accountable to Regional GM/Director for operational outcomes in a geographically defined catchment (Sector); will have an assumed knowledge of Sector population breakdown and consumer needs
- Responsibility for implementing strategic directions, policy and planning and reform processes within the Sector and actively contributes to MHS strategic planning across all Sectors
- Responsibility for implementing all relevant Models of Care in Mental Health that deliver the reform agenda of government
- Have operational responsibility for human and material resources, and monitoring of financial expenditure of the Sector
- Hold line reporting responsibility for all management and workforce issues in their Sector
- Responsible for recruitment and retention of Sector staff across all disciplines and ensure that the Sector workforce has the skill set and experience to competently assess people

at all points of the care pathway, whether they are entering the system in acute distress, or are walk in consumers or carers

- Manage annual Performance Review & Development processes for all staff within the Sector
- Responsibility for implementing a Safety & Quality Improvement Audits program
- Monitor key performance indicators monthly across the Sector to ensure that activity targets identified by Senior Management are achieved or exceeded
- Responsible for providing a safe working environment by ensuring that legislation, policies, procedures and activities that protect occupational health and safety and welfare of all in the workforce are in place
- Responsible for implementing cultural diversity and competency requirements of the Department in the local Sector, particularly for ensuring that the needs of Aboriginal consumers, their carers and families are addressed according to the core principles of the Model of Care for Aboriginal Mental Health, as described below.
- Provide leadership and support to Team Managers
- At the most senior level, actively develop, facilitate and strengthen partnerships with other agencies including primary health and General Practitioner organisations, private specialists and NGOs within the Sector, and are aware of issues that support and surround the planning and management of community mental health services

### **Clinical Co-ordinator**

This function/role is distinct from team or sector management and is not necessarily the domain of one person or profession. The Clinical Co-ordinator is responsible for providing clinical advice to all members of the multidisciplinary team, and acts as a resource/facilitator for any issues related to clinical practice.

The Clinical co-ordinator role may alternate or rotate between appropriately qualified team members, with due consideration of clinical caseload.

### **Skills**

- high levels of clinical experience and leadership skills
- approachable to all team members
- able to work alongside the psychiatrist allocated to the team on different days who will also guide clinical decision making on a daily basis.
- able to guide / direct clinical decisions when required.
- models excellence in clinical skills and professional development and practice
- promotes critical thinking and demonstrates evidence-based practice
- collaborates and consults with other health professionals

## **3.6 Safety and Quality**

The focus of all safety and quality strategies in health care delivery is to enhance consumer health and wellbeing. It is important to acknowledge that mental health service delivery, while it shares much in common with health care delivery generally, can also present quite different challenges from most other areas of health care. This is primarily because of the responsibilities related to administering legislative powers for mandatory treatment. It is critical that a balance is achieved between individual rights to dignity, respect and privacy and the need to protect the personal safety of consumers, staff and others, including families, other consumers, visitors, and the public. A

basic underpinning principle is that mandatory treatment is to be used only when less restrictive options are not appropriate, and should not be perceived or used by anyone as a punishment or coercion. The existence of powers of mandatory treatment requires mental health services and professionals to actively identify, prevent and reduce iatrogenic harm.

Safety and quality in mental health care depends on a commitment to consistently achieve the highest possible standards of care, adhere to current evidence-based practice and increase the likelihood of desired outcomes for consumers. Services will make every effort to identify, avoid or reduce actual or potential harm from mental health care delivery. Consumers and carers will be informed and involved in the planning and delivery of safety and quality programs and service improvement strategies in all adult community mental health care settings.

The application of sound governance and accountability requirements, mechanisms for service monitoring based on measurable standards, good information management practices and a motivated, well-trained workforce is vital. Good governance structures will involve transparent decision-making and clear accountability for the delivery of the best possible standards of care and continuous improvement of services. Services will be monitored and evaluated across the continuum of care to ensure the best possible health care is provided to people with mental health problems or a mental illness.

Treatment of co-morbid physical health problems and the safe use of medications for people with mental illness and mental health problems will be a key component of South Australia's quality and safety agenda. People with serious mental health illness experience far poorer physical health than the general population and the use of medications to treat psychosis can have significant adverse effects on an individual's physical health. Mental health services and professionals must be able to actively identify, prevent and reduce harm to physical health associated with treatment for mental illness.

These safety and quality priorities will include the development of a *Mental Health Safety and Quality Framework* for the implementation, evaluation and continuous quality improvement within community mental health services in line with national and state policy directions. The *Framework* will delineate the aims of high quality care in terms of safety, effectiveness, and patient-centred, timely, and efficient care domains, and include the agreed national and state performance indicators for community mental health services.

## Section 4 – Operational Guidelines

### 4.1 Service Components

Community Mental Health Centres will be the central point of coordination of service delivery - not just of those services provided out of these locations but a linked service system that engages the inputs of psychiatrists, GPs, government and non-government organisations, inpatient services, and a range of other community supports intended to sustain the person within their environment.

In all cases and across all service components, CMH Teams will:

- Maintain a philosophy of recovery from first contact
- Ensure that the core principles of recovery and citizenship inform an extended role both for consumer and carer participation and community organisation partnerships in service planning and delivery.
- Recognise each individual's abilities and strengths, not only their difficulties and disabilities
- Consider major issues identified by the consumer and where relevant, carers as requiring resolution to be considered as a priority for action
- Collaborate with the consumer, their carer and key stakeholders, to develop and maintain a current consumer's care plan and a wellness recovery action plan, founded on evidence-based best practice
- Establish and maintain collaborative partnerships with primary health care providers to ensure that physical health needs are routinely reviewed

It is recognised that continuity of services to consumers is a primary consideration, and since not all partner organisations will be located within the local CMHC catchment area, those consumers with multiple needs who access agencies and services in other areas will continue to be supported by their local Community Mental Health Centre.

In such cases, Community Mental Health Centres will establish close liaison with relevant local services and groups, and will provide a comprehensive range of information about other relevant local agencies and services and assist with referral and seamless transfer where appropriate.

Community Mental Health Centres will provide a wide range of integrated services to meet consumers' needs at various stages of their journey, which will include:

1. Acute - Emergency Response for Assessment and Treatment
2. Early Intensive Programs
3. Rehabilitation and Recovery
4. Specialised / Statewide Services
  - Perinatal disorders
  - Eating disorders
  - Anxiety disorders
  - Affective disorders (including Bipolar and major depressive disorders)
  - Severe personality disorders
  - Schizophrenia and related disorders
  - Forensic MH Service links
  - Early Psychosis Intervention

- Living & Psychosocial Interventions
- Employment options – refer also to the IPRSS and NGO Model of Care

“Hospital in the Home” services are currently provided as an extension of Mental Health Inpatient Services and are fully described in that Model of Care.

As part of the service-wide continuum of care, CMHCs will provide a keystone link to all other aspects of mental health care to ensure that no service gaps exist for consumers.

### 1. Acute Services

- Emergency response for assessment and treatment, by phone or in person, at home or in the community
- A consistent, structured referral and assessment process will exist across all aspects of mental health care service delivery sectors, statewide
- Duty Worker availability within normal hours and over extended hours
- Consultation and liaison with general hospital services including Emergency Departments, especially with respect to discharge and follow up in the community
- Culturally-competent and respectful assessment, intervention and follow up with Aboriginal members of the community and with members of various CALD communities
- Care Co-ordinator follow up contact with consumers admitted to intermediate care centres, community recovery centres and in-patient hospital care
- Care Co-ordinator follow up after discharge from acute general health service interventions, and mental health inpatient stepdown care

#### Home Treatment and Hospital Avoidance

Acute home based treatment can be a successful alternative to hospital care (Hoult, 1983)<sup>13</sup>. The target group are consumers with acute mental illness, newly presenting or with an exacerbation of a known illness, without major general medical disorder, living in a safe and stable environment with a carer network, capacity for self care and safety at home.

Home treatment will be planned and coordinated alongside the consumer and their family by the Care Co-ordinator. The Care Co-ordinator will enlist help to provide the intensity of service required.

Interventions will include the full range of clinical assessment tools and therapeutic treatments, in collaboration with carers, consumer and the GP. The mental health team may visit several times a day during the acute phase. The response would normally include peer support involvement.

Home based treatment may also be used after discharge from brief hospital admission. Peer support programs will be implemented that focus on daily living practicalities such as ensuring food is purchased, electricity connected, personal hygiene etc.

#### Consumer Needs:

- Timely access to safe, high quality emergency response and assessment when in crisis and treatment in the least restrictive environment
- Confidence that information already provided through a care plan will be shared by all professionals involved.

#### Service Responses:

- Emergency response, assessment and treatment at home where appropriate, at times as an alternative to intermediate or hospital care.
- The service will operate over seven days, with intensive home visiting for a brief duration
- Links to Intermediate care services for short term residential treatment and support.

- Links to intensive assessment and treatment which cannot be safely provided in less restrictive settings will be conducted in an acute psychiatric hospital setting.
- Following an emergency service response, plans for further treatment will be coordinated jointly by the psychiatrist and the consumer's designated community Care-Coordinator in conjunction with the consumer and their carer, and directed by the consumer's and carer's current care plan.
- The consumer's Care Co-ordinator is responsible for information sharing with the consumer and carer, other workers engaged in providing services (as agreed with the consumer) and works to implement the care plan.
- The Care Co-ordinator will take a lead role in the **co-ordination** of all aspects of care.
- The lead role may include direct involvement in assessment, care planning and treatment whether the setting be acute care in the home, intermediate care facility or in the hospital.

## 2. Early Intensive Community Programs

CMHCs will provide intensive recovery-focused treatment and care for consumers early in the course of serious illness.

In some Sectors, where the professional capacity exists, Early Psychosis services for younger people may be provided in collaboration with CAMHS services, and may also provide these services to consumers from other Sectors. In doing so, firm adherence to standard assessment, intervention, documentation and transfer of care processes is required to ensure consistency and continuity of service and records.

Consumer Needs:

- Prompt access into services which can recognise their needs, establish a diagnosis and provide treatment

Service Responses:

- Routine exploration and discussion must occur with the consumer and their carer of how multiple factors impact on the consumer's life, with referral to the agency or services required to meet that need, as agreed to with the consumer and their carer.
- CMH Teams will maintain engagement with consumers and carers, at times intensively, when the consumer has difficulties over several domains – for example, illness symptoms, substance use, unstable accommodation, poverty, problems with self care or social skills.
- Intensive rehabilitation programs will provide community based support and day programs to assist consumers in their journey towards recovery. (See below)

## 3. Clinical Psychosocial Rehabilitation Services

Clinical psychosocial rehabilitation programs deliver clinically based interventions which incorporate both group and individual interventions delivered by multidisciplinary teams of clinical and non-clinical staff. Programs will facilitate and support consumer involvement in planning, implementing and evaluating programs.

Sector Managers will ensure that all staff providing such interventions receive the appropriate professional clinical supervision and support.

The role of clinical psychosocial rehabilitation programs is to provide comprehensive assessment delivered by skilled clinicians in conjunction with the consumer to identify functional capacity and therapeutic intervention goals. The assessment informs individual goal setting and the development of individual and group therapeutic interventions based on:

- Individual consumer needs as identified through evidence based outcome measures such as BASIS32, K10+, HoNOS, LSP, surveys and consultation meetings.
- Assessment tools such as the Model of Human Occupation (MHO), the Assessment of Motor and Process Skills (AMPS) or other standardised assessment tools for function.

Services may include a range of training programs including living skills, self-management, vocational rehabilitation, therapeutic activities, community development projects, joint agency partnerships, consumer empowerment and consultation.

**Consumer Needs:**

- Access to an appropriate range of professional and non-clinical programs.
- Access to a variety of opportunities through government and non-government organisations and other agencies.

**Service Responses:**

- CMH Teams will provide mental health specific expert advice to consumers, their carers, psychosocial rehabilitation and support providers, housing management providers and other key stakeholders.
- CMH Teams will provide access to a range of clinical assessments and treatment options, including but not limited to occupational therapy living skills assessment, psychological assessments and treatment, risk assessment and diagnostic assessment.

#### **4. Living and Psychosocial Interventions**

**Accommodation Options:**

- Intensive support with residential component (CRC) Refer to CRC Model of Care.
- Less intensive support. (more info please)
- Assisted access to independent living and support services.
- The identification of consumers' housing and accommodation needs is an essential part of the initial and ongoing assessment process, as there is strong evidence to indicate that stability in housing is an essential component impacting directly on a consumer's recovery.

**Employment Options:**

- Satisfying work or activity is essential to a person's recovery. Integrated service delivery is best practice for enabling mental health consumer employment outcomes. Community Mental Health Teams will include NGO employment specialists, working in partnership; care and employment plans will be integrated.
- Consumers, carers, psychiatrists, Care Co-ordinators, psychosocial rehabilitation workers and employment specialists will collaborate to ensure education, training and employment and/or activity goals are addressed
- Progress towards consumer employment/activity goals is never deferred until the consumer is "more recovered". When the expressed consumer goal is mainstream work or study, the Community Mental Health Team will provide the necessary referrals and support at the earliest opportunity.
- When the consumer goal is an(eg physical or creative), the CMH Team will arrange access to relevant specialists, support or special interest groups, and will retain involvement with the consumer and carer to ensure satisfactory progress is being achieved.



- The employment specialist will discuss employment history, aspirations and skills with the consumer and carer. A plan for reaching the goals will be developed collaboratively and job-search commenced rapidly. Support will be provided for as long as it is needed, within and/or outside the workplace, according to consumer, carer, trainer and employer preference.
- Employment goals will be discussed by consumers, carers and mental health teams routinely in three-monthly clinical reviews and at other times as required. Treatment and support will be adjusted to best support consumer employment goals.

## 5. Specialised Services

Consumer Needs:

- Local response (assessment and/or treatment and rehabilitation) for mental health problems with differing or complex presentations
- A standardised, quality response and referral pathway for people with high prevalence disorders such as anxiety and depression.

Service Responses:

- All CMHC Sectors will ensure consumer access to the full range of specialist services, whether provided locally or with another Sector or agency.
- Partnership with Drug and Alcohol Services South Australia (DASSA). Due to the increasing prevalence and treatment issues associated with co-existing drug or alcohol dependency, a close partnership between each Community Mental health Team and the nearest DASSA team is essential.

## 4.2 Key Service Components

### 1. Assessment

The primary documents governing Assessment are the *Statewide Assessment for Adults and OPMHS Tool* and *Business Rules* that support that document, issued by SA Mental Health for use by all clinicians statewide to ensure consistency across all points of service delivery.

To fully inform the needs the consumer identifies, the assessment processes used by clinicians will:

- Focus on the person and the issues that impact on their functioning within their environment – not solely the issues relevant to the nature of the illness.
- Focus on the consumers demonstrated resilience and capacity to meet their needs over time.
- Include psychiatric, psychosocial and social functioning domains, including an analysis of risk to self and others, both current and historical.
- Employ a holistic approach with housing, financial and occupational status included from a strengths perspective.
- Include an examination and information on general physical health
- Identify any co-morbidity problems in terms of disability and poly-substance misuse.

## 2. Care Coordination

Care coordination is a critical element in the provision of a transparent seamless service for the consumer and their family. This process will be provided by the Care Co-ordinator, to ensure clear oversight, effective management/follow-up and integration of services supporting consumers.

Excellent partnerships and clear communication protocols and processes are required for effective care coordination.

## 3. Therapy

Therapy is defined as an evidence-based intervention provided by trained and supervised professional staff. Sector Managers will provide oversight and will co-ordinate this to ensure fidelity across Sectors and to ensure equity to consumers and their families.

Clinical Protocols will exist to ensure that the right type of therapy is given at the right time and evaluation mechanisms will exist that assess therapy outcomes.

## 4. Transfer of Care

Standardised protocols will exist across all mental health care service providers to ensure seamless transfer of care occurs for consumers across all aspects of service delivery. All aspects of the transfer of care process must fully involve the consumer, carer and significant others, with consumer consent, at each stage along the pathway of care.

Uniform protocols will exist to ensure clear, consistent interpretation and application of the transfer process.

### 4.3 Key Therapeutic Interventions

A range of evidence-based treatment programs will be available as a minimum in each Community Mental Health Centre based on individual consumer's needs. These will include Psychological Therapies (which may be delivered by various clinicians); Physical Therapies; Living and Psychosocial Interventions.

A clinical review process must be established before introducing new or innovative treatments, based on evidence of likely benefit, and ongoing evaluation.

All staff will be expected to engage in clinical supervision, both of and by their peers, to ensure the delivery of best practice therapies.

### 4.4 Workforce Organisation

The following Operational Details of work organisation describe processes and organisational arrangements across all Community Mental Health Centres, where all staff will operate as an integral part of one team. Variation may occur between Sectors offering different services.

- Sector Managers will provide overall management of Community Mental Health Teams in their Sector
- Team Managers will be senior clinicians who may or may not also carry a caseload.

- The Team manager will take an active role in the management of incoming service demand, the worker allocation process and prioritisation of response.
- Individual workers will be allocated to work within the context of overall workload management for the Team and then on the basis of 'best fit' with consumer need and worker skills, knowledge and expertise.
- Workers will manage a heterogeneous and diverse caseload with consumers at various points on the "care pathway".
- Workers with recognised specialist skills will be involved in the provision of care without needing to be the sole worker involved.
- The allocation of work will occur at team level rather than solely in consultation between the worker and their supervisor.
- All members of the team will participate in decisions made about case allocation, case management and Clinical Co-ordinator assignment.
- The process of allocation will occur on a daily basis and is reviewed via a team clinical review meeting held weekly.
- A transparent process will be used to review progress for all active consumers as part of the weekly team meetings. For example, the 'Zoning Board' model implemented in some districts in New Zealand has merit in ensuring the best fit of skill resource available and consumer need.
- On a 3-monthly basis, a formal review of the Consumer Care Plan is undertaken with the consumer, carer and significant others involved.
- Caseload capacity is identified within the team for the provision of crisis and emergency response, including after hours response.
- CMHC team staff will work across both hospital and community settings. A proactive focus will be placed on in-reach services to Emergency Department (ED) services and the creation of alternatives to EDs or crisis intervention being the first or recurring point of entry into the service system.

#### **4.5 Care Co-ordinator Functions**

- To be the named primary contact point for a consumer, the point of navigation assistance, and the person to whom the consumer can return for assistance in resolving issues with the service system
- To support, assist, advocate, broker, mentor and to provide the point of continuity for the consumer across coordinated services
- To ensure that a comprehensive assessment is undertaken, which forms the basis for the care plan
- To ensure that an individual care plan is developed with the consumer, outlining their goals strategies and responsibilities
- To ensure the facilitation and implementation of a consumer's care plan
- To review the care plan with the consumer at least every 3 months
- To ensure that appropriate arrangements exist and to facilitate the transfer of care within public mental health care services when required
- To promote and assist the consumer to develop self-management skills

## 4.6 Consumer Allocation and Review Process

Team based reviews will occur for the following purposes:

- **Daily Team Review** – This mandatory central meeting explores team based clinical support, the allocation of new referrals, and assessment of status of current crises and the necessary implications to resource allocation for individuals and the team. It requires a transparent review of the status of each clinician's case load, which informs the allocation process and the capacity to assist each other in being responsive to increases in consumer needs at times of crisis. This meeting will be critical for all to attend, and no other meetings should be arranged at this time. This daily meeting will assist the team in flexibility, resource allocation, communication and transparency.
- **Clinical reviews** – all services delivered to each consumer in respect to their needs and goals will be peer reviewed at a minimum every three months in accordance with National Mental Health Standard 11.3. This review will be part of, or an input into, the operating level review referred to in 6.2.2. These peer reviews will be informed by a prior scheduled (e.g. weekly) review which ideally will involve the active participation of the consumer (National Standards for Mental Health Services 11.4), the Carer (Carers Recognition Act 2005), the designated care coordinator / Care Co-ordinator and any other relevant parties including but not exclusive to NGOs, consultant psychiatrists and GPs (National Standards for Mental Health Services 8.2 and 8.3)<sup>19</sup>. Hence the peer review with the multidisciplinary team will occur as a parallel process and in addition to the direct review occurring with the consumer present.

## 4.7 NGO Responsibilities at Sector Level

*Refer also to the IPRSS and NGO Models of Care.*

Under this Adult Community Model of Care, non-government sector agencies will provide a range of support functions consistent with individual need, which will form an integral component of a networked team of skilled practitioners engaged in supporting the individual's recovery. SA Mental Health has well-defined and accepted processes for the delivery of NGO services.

There are clear advantages to NGOs working within the catchment area of their nearest Community Mental Health Centre, however, where a specific NGO service is not provided within their local CMHC area, consumers will be supported by consistent and transparent processes to ensure that no detriment to service occurs.

NGOs, like any other agency, can act as centres of excellence for a specific service or technique across more than one Sector.

## 4.8 Safety and Quality in Operation

The Community mental health services will operate under the safety and quality principles and priorities described within the *South Australian Mental Health and Wellbeing Policy (draft)* articulate with the National Standards for Mental Health Services, Australian Council for Healthcare Standards, the National Safety Standards, and Key Performance Indicators for Australian Public Mental Health Services.

These safety and quality priorities will include the development of a *Mental Health Safety and Quality Framework* for the implementation, evaluation and continuous quality improvement within community mental health services in line with national and state policy directions. The *Framework* will delineate the aims of high quality care in terms of safety, effectiveness, and patient-centred, timely, and efficient care domains, and include the agreed national and state performance indicators for community mental health services.

Priorities to ensure consistent, safe and evidence-based practice in mental health service delivery under the *SA Mental Health and Wellbeing Policy* the following clauses must be addressed across all CMHCs and the wider mental health care service system:

#### Consumer and community participation

- Ensure that consumers are informed and involved in all aspects of safety and quality programs, ensuring that feedback on service is provided to health professionals and that consumers are involved in the planning and delivery of services and service improvement strategies.
- Ensure information about outcomes of care and the performance of the health care system is shared with health care providers and the public.

#### Governance and accountability

- Develop and implement a comprehensive *Mental Health Safety and Quality Framework* incorporating national mental health safety priorities
- Ensure good governance structures are in place, that decision-making is transparent and there is clear accountability for the delivery and continuous improvement of services.
- Ensure that resources are used appropriately and responsibly
- Ensure effective complaints management processes are in place and addressed.
- Ensure that appropriate processes are in place for the management of adverse events.

#### Monitoring and Evaluation

- Ensure that services are monitored and evaluated across the continuum of care to ensure that the best possible health care is provided to people with mental health problems or a mental illness.
- Ensure that safety and quality audits and risk assessments are undertaken
- Ensure that monitoring systems are based on measurable standards, with appropriate benchmarking and outcome measures.

#### Physical Health and Wellbeing

- Prioritise the physical health and wellbeing of people with severe mental illness, ensuring that their physical health is assessed and monitored and that they receive evidence-based medical care, particularly where physical health problems are associated with the use of psychotropic medication to treat a mental illness.
- Increase the understanding of the relationship between physical health and mental health across primary and specialist health care services and in the general community.
- Ensure intervention for co-morbid physical health conditions occurs at the onset of illness, with a particular focus on the physical health needs of young people experiencing early psychosis, including diet, exercise and lifestyle education and support.

#### Safe use of medicines

- Ensure the use of medications has a sound evidence base and takes into account potential side effects and other adverse reactions that may affect a person's mental and physical health needs and is in compliance with relevant policies and procedures governing the use of medication.
- Clear documentation and record keeping of all medication treatment history, and current medication regimes
- Reduce and eliminate where possible the use of multiple psychotropic medications in the treatment of people with psychosis.
- Facilitate partnerships between general practice and mental health professionals in relation to the medical treatment of people with a mental illness to achieve the highest possible standard of care and consistency of treatment regimes.

- Support further research and the collection of accurate data on the use of medications to inform policies and procedures governing the best practice use of medications.

Reduce adverse events, suicide and deliberate self harm in mental health services

- Ensure mental health assessments, including risk assessments and physical health assessments are conducted and in a timely manner
- Ensure the recommendations and strategies are incorporated into consumer care plans
- Ensure risk management and care plan strategies are communicated with the consumer and all involved in the care of the consumer and are consistently implemented
- In the event of an adverse incident involving a registered mental health consumer such as suicide or serious suicide attempt, the community mental health team are also responsible to communicate with the consumers' family and carers and offer/provide them with appropriate mental health support services.

Safe and appropriate transport

- A range of transport options are considered to ensure that appropriate, respectful and least restrictive practices are adopted in transporting consumers for the purpose of facilitating treatment

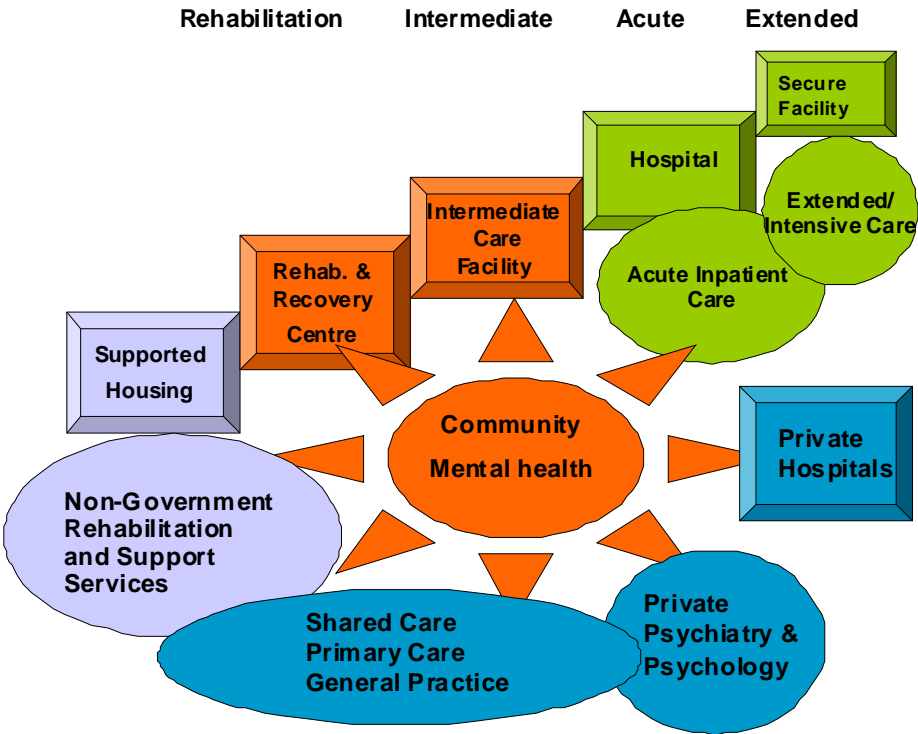
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Appendix 1: Community Mental Health Care at the Centre of the System



## Appendix 2: Recovery<sup>5</sup>

Recovery refers to the ways in which a person with a psychiatric disorder manages his or her disability in the process of reclaiming his or her life in the community.

Recovery-oriented care refers to what psychiatric treatment and rehabilitation practitioners offer in support of a person's recovery.

Recovery is not a term for what the service system does *to* or *for* people with mental illness. Rather, it will refer to people taking advantage of opportunities and utilising the supports and services/tools he or she needs in order to be successful in the ordinary life tasks of loving, working, playing, and belonging. It is the responsibility of the system to ensure that options exist to facilitate and support individuals in their recovery (Davidson, 2004<sup>4</sup>; CHSA 2006<sup>5</sup>).

The key building blocks of recovery have been identified as:

- Belonging and acceptance from caring others
- Renewed hope and commitment
- Involvement in meaningful activities in the community
- Redefining the illness as only one aspect of a multidimensional sense of self (rather than having one's self and life defined by the illness)
- Incorporating illness
- Finding ways to manage the symptoms
- Overcoming stigma
- Assuming control, experiencing successes and pleasure
- Empowerment, reciprocity and giving back to, and regaining citizenship in, the broader community (Davidson, 2004<sup>4</sup>)

Recovery is an orientation that has at its core an acceptance that the individual is always capable of change - to adapt, conquer, surpass; to amend, control, and express their individuality and unique contribution to their own lives and those of others. A recovery approach orientation provides prompts to ask the questions which invite the consumer to participate as a citizen - to fully participate in their own life and to accept increasing responsibility in influencing *their* life experience.

A useful definition that has resonance to those that experience mental illness (and often referenced) is that proposed by Anthony (1993<sup>3</sup>):

*'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.'*

A somewhat broader definition also emphasises the importance of recovery as a journey, but with the ability to heal and be transformed by the experience - or even in spite of it:

*'Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.'* (USNCC, 2004<sup>6</sup>)

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<sup>5</sup> Refer also to National Recovery Principles (draft, 2010)

Although a focus on recovery is fundamental to the provision of mental health services, the team will recognise two vital areas of difference between individual consumers:

1. each individual's recovery journey, and realisation of recovery, is different;
2. the illness stage at which each individual becomes receptive to working towards recovery differs.

The recovery focus in turn relies upon a number of related principles, which will be used by the team in assisting consumers in their individual journeys of recovery:

- **Self Directed** – Consumers lead, control, exercise choice over, and determine their own path of recovery by optimising autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Non-linear** – Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognises that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths Based** – Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The consumer moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support** – Mutual support, including the sharing of experiential knowledge and skills and social learning, plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect** – Community, systems, and societal acceptance and appreciation of consumers - including protecting their rights and eliminating discrimination and stigma – are crucial in achieving a place of wellness. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility** – Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must seek to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope** – 'Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalised; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

### **Consumer Centred**

The consumer is our *raison d'etre*. The services we provide are directed by the needs of the consumer - the consumer is the focal point for our service delivery and everything we do must be capable of justification on the basis of meeting consumer need, facilitating the individual's recovery and supporting them in their journey.

We believe in the uniqueness of the individual and the importance of our service system's ability to meet individual needs. The state of mental health and wellbeing is an immensely

personal state of being. Our service system, and in this context our community mental health services, must be capable of responding to an individual's needs and to take direction on the basis of those needs. For example, we need to resist the way of working in which we rely solely upon a narrowly determined diagnosis, so that we always look at the person as we would expect to be treated.

Consistent with this belief is the engagement of consumers at each level in the decision-making process. Service planning, policy development, operational management procedures, service protocols, inter-agency agreements, memoranda of understanding, service delivery provisions - all are the province of consumers to contribute to and influence. "Nothing about us without us."

### **Holistic**

Clearly, a focus on mental health and well-being ('a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity') requires not a focus on the signs of disease, but rather on the person in the context of their social and cultural environment. We seek to support people with their natural supports and we do not seek to replace them with a health care-based support structure. Our focus needs to be on what the consumer states is their support structure, not one imposed on the basis of what we think the support structure should look like.

### **Empowerment**

Consumers have the authority to choose from a range of options and to participate in all decisions - including the allocation of resources- that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organisational and societal structures in his or her life.

### **Prevention, Early Intervention**

A key principle of the Community Mental Health Service is that effective preventive and early intervention measures, coupled with sound primary health care, will minimise the need for crisis, acute and emergency actions. To this end, the team will follow these strategies, and will encourage consumers, GPs and partner agencies to do likewise.

### **Partnership with Family and Significant Others**

The service works in partnership with consumers and their family in the least restrictive way and commits to the premise of not "doing for" but "doing with", and seeking to ask the questions that help the person to learn more about themselves and their initiative.

## Appendix 3: Literature Review Community Mental Health Service Structures

### **CHANGE**

Change in the delivery of mental health care has escalated in the last four decades, more so than in other parts of the health system. More than a century of the 'rise of the asylum' (Tansella, 2005), since the late 1950's, large mental hospitals have been dramatically reduced in size or closed. Across Australia, the number of psychiatric inpatients per 100,000 population has reduced from 400 to less than 50. (Rosen, 2001).

In South Australia, inpatient numbers peaked at about 2900 in the early 1960's, most of the subsequent reduction occurred in the 1970's and early 1980's. Some early de-institutionalisation was actually 'trans-institutionalisation' as separate facilities were established for people with intellectual disability and as older inpatients moved to nursing homes.

However, many people moved to community accommodation as hospital beds closed. Large, older residences were converted to boarding houses or units; in the 1960's and 1970's, such buildings were able to be used for relatively cheap accommodation.

### **SERVICES**

Numerous studies have replicated Hoult's work in Sydney (1980), including work at the Maudsley in London (1994). These demonstrate that acutely unwell patients can often be managed at home, with outcomes at least as good as hospital care. The 'training in community living' program developed during the 1970s in Wisconsin, USA (Stein 1980) was the model for assertive community treatment. The Team for Assessment of Psychiatric Services (TAPS) has shown that with appropriate services and re-provisioning, long-stay patients discharged from psychiatric hospital can thrive (Leff, 2000).

Across the developed world, re-investment in community services has not matched reductions in hospital care, (Leff, 2001). Cost-effectiveness studies on de-institutionalization and of community mental health teams have demonstrated that quality of care is closely related to expenditure. (WHO, 2003)

The literature on evaluation of community care addresses overlapping issues of effective delivery of interventions and delivery of effective interventions – sometimes confusing the themes.

### **EFFECTIVE DELIVERY OF SERVICES - SERVICE ORGANISATION**

For developed, high-resource countries, there is some agreement, though at times limited evidence, about core functions of CMH services (WHO, 2003). Effective services address both health and social services.

Case management has been well established as a major component of mental health services in most developed countries for over twenty years.

Studies of case management teams cover a wide variety of service arrangements, target groups and workforce mix. Inherited from the days of large-scale de-institutionalization, the core function of the case manager was to help a consumer navigate the myriad of agencies necessary for community living and mental health treatment – previously provided by the hospital.

As community based services have developed, comparing 'standard case management' with often similar 'treatment as usual' groups have sometimes shown little benefit (Marshall, 1998). This

argument is further supported by Simmonds (2001) who concluded that case managed community care appears preferable to hospital care.

Evidence suggests that maintaining a better contact with consumers is one clear outcome of case management.

There is a significant literature and debate about conflicting reported results, concerning Assertive Community Treatment teams (ACT). The general conclusion is that well structured ACT is of proven benefit for the most disabled community clients (Rosen, 2001, Cuddeback, 2006).

Asserting styles of intensive case management are effective in reducing the number of days spent in hospital and improving engagement with services, compliance, independent living skills and client satisfaction (Marshall, 1998).

Rosen (2001) has questioned whether combining ACT with community crisis team functions in some studies of ACT has reduced the effectiveness of the latter.

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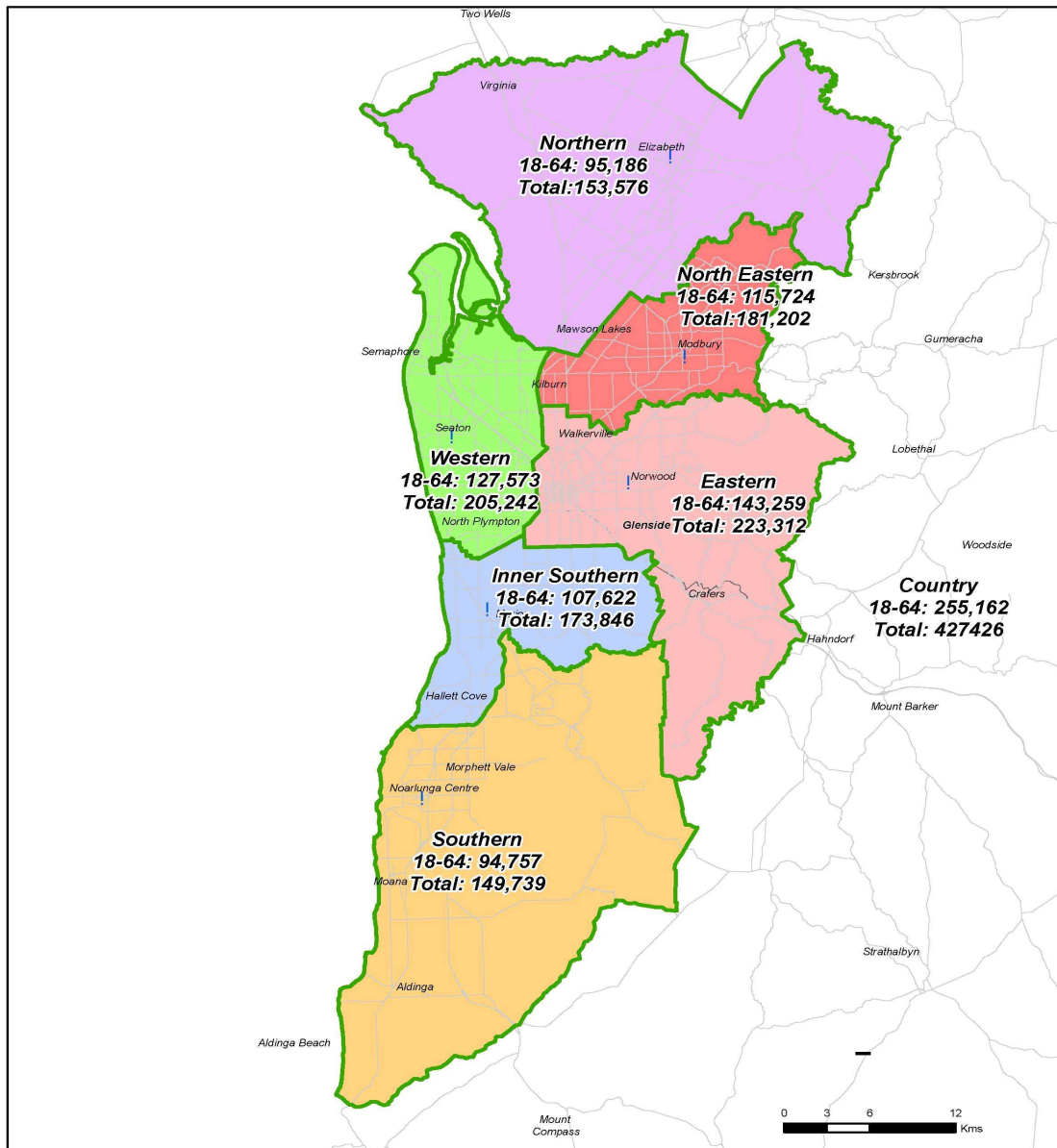


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## Appendix 5: Sector Map

**2006 Population by Region  
Totals and 18-64 years**



- ! Proposed sites (estimated)
- ▭ New Regions
- Main Roads

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