

# Mental Health Services Plan 2020-2025



Government  
of South Australia

SA Health

# SA Department for Health and Wellbeing Mental Health Services Plan



Government  
of South Australia



## Vision

The SA Department for Health and Wellbeing will commission mental health services of the highest quality, that are effective and safe, uphold human rights, enhance wellbeing and support people to fully participate and thrive in their chosen community.



## Goals

### > PERSONALISED CARE

Respectful of the needs and preferences of the individual and affords them dignity and active participation in all support, care and treatment decisions

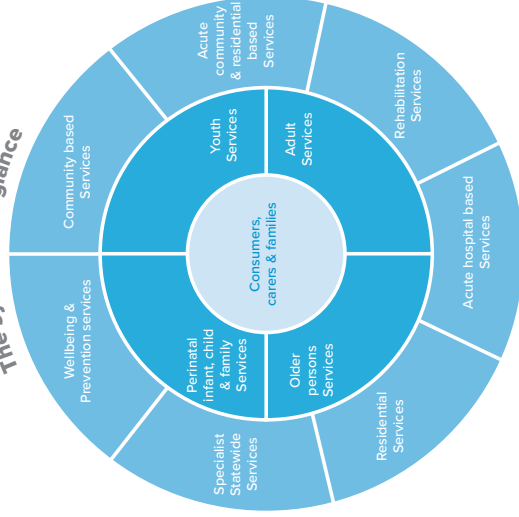
### > INTEGRATED CARE

Supporting a more holistic service approach that focuses on the whole person, recognising and supporting their mental health, physical health and social needs through improved partnerships, collaborative care planning and continuity of care.

### > SAFE AND HIGH QUALITY CARE

Ensuring that services are planned and delivered to the highest quality, are safe, respectful and protect the rights of all who utilise services.

The system at a glance



## Key priorities

**Community alternatives:** timely access to community-based care earlier in the course of illness and early in episode

**Human rights:** ensuring human rights are respected, protected, and fulfilled, with a reduction in coercion

**Peer workforce:** peer workers will be incorporated as an integral component of mental health service delivery

**Effective Suicide Prevention:** commitment to a Towards Zero Suicide initiative within our tertiary mental health services

**Access to therapies:** Providing greater access to a range of evidence based therapies

**Equity of access to services:** ensuring people in South Australia have equitable access to services wherever they live, including people in rural and remote communities

## Supporting people who are more at risk:

Aboriginal People  
Children, young people & families  
Older persons  
Culturally and linguistically diverse backgrounds  
People in isolated rural areas

Veterans and First Responders in the Correctional or Forensic system  
Young people in the justice system  
Gender and sexually diverse

People with a disability  
Substance use issues  
Chronic health conditions  
People experiencing other forms of social disadvantage

## The outcomes identified in the Plan

Outcomes
1. People receiving services are actively engaged as partners in their care
2. Perinatal, infants, children and families have improved access to and engagement with mental health services and support
3. Young people (12-24) have positive mental health and early intervention service access for any emerging mental health issues
4. Aboriginal and Torres Strait Islander people have access to culturally safe and appropriate initiatives determined by local communities
5. Older people have access to mental health programs and support that reduce the impacts of mental illness
6. People obtain timely and effective mental health care and support that promotes wellbeing and respects diversity
7. Services work together in partnership to provide a coordinated response to meet people's individual needs
8. People with a mental illness will have better physical health and live longer
9. Improving safety and quality in mental health services to reduce harm, uphold human rights and support inclusion
10. Mental health services promote fairness, inclusion, tolerance and equity in all interactions
11. The workforce is supported to provide the best care

## New clinical models to develop during the life of the plan:

SA Aboriginal Mental Health and Wellbeing Centre of Excellence
Urgent Mental Health Care Centre
Embedding mental health services into other settings including child and youth services and emergency services
Towards Zero Suicide initiative
Prison In-reach Mental Health Services and expansion of James Nash House
Dementia Units and Rapid Access Service (into aged care facilities)
Crisis Retreat Centre and Safe Haven Cafe
Re-vamped telephone crisis and support line

## Key facts (annually)

CONTACTS IN OUR COMMUNITY MENTAL HEALTH SERVICES  
**690,000**

ED PRESENTATIONS  
**20,700**

ACUTE ADMISSIONS TO HOSPITAL BEDS  
**9,200**

CLINICIANS AND STAFF  
**2,600**

ACUTE BEDS  
**377**

NON-ACUTE BEDS  
**92**

RESIDENTIAL BEDS  
**146**

METRO TELE-PSYCHIATRY UNITS  
**86**

COUNTRY TELE-PSYCHIATRY UNITS  
**20**

## Future state

- > Priority expansion of:
  - Child & Adolescent Mental Health Services
  - Forensic Mental Health Services
  - Older Persons Mental Health Services
- > Use of Urgent Mental Health Care Centres
- > New crisis model (telephone, community and residential)
- > New residential based services for youth, adults in crisis, and older people

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# Foreword

As the State's Chief Psychiatrist and Mental Health Commissioner we were tasked with developing a new Mental Health Services Plan for South Australia. Our offices worked in close collaboration to develop a Plan that provides a renewed five-year vision for the delivery of Department for Health and Wellbeing operated and commissioned mental health services in the State. The Plan builds on the extensive consultation undertaken in the development of the SA Mental Health Strategic Plan 2017-2022 and provides the Government with a foundation for the commissioning and delivery of high-quality mental health care for people in South Australia.

During the development of both the SA Mental Health Strategic Plan and the Mental Health Services Plan, consumers and carers told us that the current mental health system is difficult to navigate and that people don't always know where to go for help. People told us they find emergency departments distressing and they want better access to alternative options much earlier. People also told us that they can be connected with multiple services that work in isolation, leading to confusion, and potential gaps.

Population based frameworks also highlighted the need to better address services for children and young people, and for older people.

This is an outcome-based plan focused on the key priorities of personalisation, integration and the safety and quality of services; themes that the plan explains in detail. Expectations are set by the plan, but they will need to be implemented locally by the providers of our services in close consultation and collaboration with consumers and carers.

The Plan seeks to ensure that human rights are honoured and protected. It sets an enduring expectation that those receiving care are engaged as active and valued participants in every interaction. The Plan also seeks to enable staff to deliver best practice in an effective, efficient and rewarding way, and provides for an expanded role for peer workers.

Consultation does not stop with the release of the plan. Our Officers will be travelling across the state to consult on how the high level outcomes and expectations of the plan are turned into reality. Also while we are proud of the best practice outcomes and strategies included in this plan, we also recognise that new and emerging approaches can develop that require a response. We consider that the goals of this plan – personalisation, integration and safety and quality, will give our systems flexibility to absorb new ideas over the life of the plan.

In releasing this Plan we wish to acknowledge the many staff, consumers, carers and community members who attended forums, gave written feedback or were members of one of six Working Groups that developed key elements of the plan. We also wish to thank the members of the Steering Group who brought the key ideas together. And, of course, the writing team that has brought together a vast breadth of thoughts and ideas into a cogent and succinct plan.

We are pleased to offer this Plan for the SA Government's consideration, as a blueprint for prioritising mental health service initiatives for people in South Australia. This will require ongoing work and commitment as initiatives are implemented, evaluated and then further refined. By the conclusion of this Plan, people in our State will have access to services that are more accessible, safer, more effective, and uphold human rights.

**John Brayley**  
Chief Psychiatrist

**Chris Burns**  
Mental Health Commissioner

We acknowledge the Aboriginal people as the first Australians, traditional owners of South Australia, and respect their ongoing living and spiritual relationship with the land and sea. We respect and celebrate the many Aboriginal peoples and lands across the state.

## Acknowledgements

SA Department for Health and Wellbeing, the Office of the Chief Psychiatrist and the SA Mental Health Commission acknowledge the valuable contributions of many different people throughout the development of the Mental Health Services Plan. This includes people with a lived experience, families and carers, community members, clinicians, service providers, managers, organisational leaders and members of the project work groups and project steering group.

# 1. Introduction

Mental health is a state of wellbeing where an individual can thrive in their chosen community, work through adversity, meet their needs and find meaning and purpose in their life. Mental illness and mental health concerns can have a substantial impact at the personal, social and economic levels in our community and its impacts are among the greatest causes of disability, reduced quality of life and productivity. Providing access to services that support people to recover in the community will deliver long term benefits for individuals, families, communities and government.

While South Australia has a range of high quality mental health care options available, it is not always accessible at a time and place for those who may need it. The accessibility and type of services can also depend on where people live. People can wait excessive times to be seen, experience gaps in services and follow up, and be impacted by the system when it applies excessive coercion that may have been avoidable.

The Mental Health Services Plan (the Plan) provides an opportunity to build on what has been working well and to re-shape how services are accessed and delivered in future to support better outcomes for consumers and staff. It sets the future direction for state government funded mental health and wellbeing services and rebalances the system towards community alternatives as well as consumer and carer empowerment. It articulates best practice expectations for improved services and delivering better outcomes for all, including people living in regional and remote areas.

The Plan builds on the vision and direction provided by the South Australian Mental Health Strategic Plan 2017 – 2022, published by the SA Mental Health Commission in 2017.

In 2019 a number of initiatives are already underway in South Australia that are either consistent with the plan's principles and directions (eg new services delivering specific therapies) or have been influenced by the discussions associated with the development of the plan (expanded forensic capacity, an Urgent Mental Health Care Centre, and the commencement of a Towards Zero Suicide Initiative). The plan offers a strategic investment in mental health services, to avoid reactive one off responses to demand that can be less effective and not efficient.

The Plan identifies 11 outcomes which are underpinned by three high level goals:

## Personalised care and support

1. People receiving services are actively engaged as partners in their care
2. Perinatal, infants, children (0-12) and families have improved access to and engagement with mental health services and support
3. Young people (12-24) have positive mental health and early intervention services access for any emerging mental health issues
4. Aboriginal and Torres Strait Islander people have access to culturally safe and appropriate initiatives determined by local communities
5. Older people have access to mental health programs and support that reduce the impacts of mental illness

## Integrated Care

6. People obtain timely and effective mental health care and support that promotes wellbeing and respects diversity
7. Services work together in partnership to provide a coordinated response to meet individual needs
8. People with a mental illness will have better physical health and live longer

## Safe and High Quality Care

9. Improving safety and quality in mental health services to reduce harm, uphold human rights and support inclusion
10. Mental Health Services promote fairness, inclusion, tolerance and equity in all interactions
11. The workforce is supported to provide the best care

### Alignment with national reform

The Plan aligns with the expectations of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) (Department of Health 2017).

### Governance and leadership

- > The accountability for implementing this Plan rests with key leaders with different authority. As the Plan guides the commissioning of services, the Chief Executive of Health has ultimate oversight. The Plan also has a strong emphasis on therapeutic interventions, upholding rights, and the safety of services, all of which fall within statutory functions of the Chief Psychiatrist.
- > When it comes to service design, operationalisation, and achieving goals for specific locations and population groups, accountability will rest with the Boards of Local Health Networks (LHNs) and NGOs that have been commissioned to deliver the outcomes of this Plan. However for any service changes or new services that have resource and accountability impacts, these will need to be articulated in Service Level Agreements and agreed by Local Health Networks.
- > The LHNs will work collaboratively with the DHW in supporting the strategic direction of the Plan, ensuring local projects that have a mental health focus are aligned with the Plan and the intent to deliver quality and consistent mental health care across the state
- > The Chief Psychiatrist will convene an oversight group to develop an implementation plan and to monitor the achievement of goals against the Plan.
- > The existing DHW Mental Health Leadership Group will provide a forum for collaborative action across LHN operated services, ensuring that state-wide services required by this Plan are delivered in a coordinated way.

### Evaluation and Outcomes

- > The implementation of this Plan will be independently reviewed at three time points: 18 months, three years and at five years with agreed performance expectations linked to each review stage.

#### KEY FACTS AT A GLANCE (ANNUAL)

**\$423.1m**

Expenditure Budget

**2,600**

Clinicians and staff

**690,000**

Contacts in our community mental health services

**615**

377 acute beds  
92 non-acute beds  
146 residential beds

**20,700**

People presented to an Emergency Department or 57 per day

**9,900**

People came to an Emergency Department by ambulance

**9.2 hours**

Average visit time to Emergency Department

**9,200**

Admissions to acute hospital beds

**120**

Admissions to non-acute beds

**1,100**

Admission to residential service beds

**13 days**

Average general acute length of stay

**14%**

General acute readmissions rate

Annually based on 2018 DHW Clinical Databases. Emergency Department data for the entire state (metro and country), visit time statewide, acute length of stay excludes short stay units.



## 1.1 Why do we need a Plan?

The Mental Health system in South Australia has become a complex patchwork of success and areas of failure. The commitment of individuals in our system can be celebrated however skills and commitment of individuals is insufficient if systems are not operating effectively.

Differences in opinion about service modelling and priority setting exist. Getting the balance right between community and inpatient resourcing, early intervention, acute services and rehabilitation can be a part of those debates. The Plan relies on national modelling to set priorities in the coming five years, but it does not seek to impose a rigid master plan of where any new funds should be allocated or existing funds redirected. Key priorities emerge from the population modelling such as services for children, adolescents and older people, and more community alternatives for all age groups. The Plan has taken this approach in the context of an ever changing environment, and even the National Mental Health Services Planning Framework (the Framework) tool used for the modelling is subject to review.

Other priorities have been identified independent of the Framework modelling for the entire population, including the need for a new service for Aboriginal people. The Framework does not guide the planning of forensic services as the settings for those services are determined by local legislation.

While the Plan leaves room for ongoing evolution and change in the balance of services commissioned over the next 5 years, what needs to stay non-negotiable are the fundamental goals of the Plan and the vision of the high quality, rights affirming services that will be delivered. The Plan will need to make a tangible impact at a critical time.

A plan is needed not just to guide possible future resourcing, but also to enable the safe stewardship of the state's existing investment in Mental Health Services which is now just over \$400 million per year. An agreed Plan allows collective action across our mental health sector and a determination to implement strategies to achieve effective and sustainable change.

The Plan needs to revisit key areas that have been the focus of previous reform attempts and only partly implemented.

- > The Plan emphasises the requirement for a mobile crisis response, initially in collaboration with ambulance and police but then with the proposal of establishing mobile teams using a new model.
- > It highlights the need to enhance home based treatment programs through the delivery of more evidence based therapies, interventions, and quality improvement programs.

- > The needs of youth will be addressed through better integration with other youth services. While the need for extra resources is acknowledged, the experience in other states demonstrates that more can be achieved when youth is a priority objective.
- > While the Plan focuses on consumers and carers it must also deliver for staff. Working in mental health must be rewarding to retain our current workforce whilst also attracting new staff, so as to improve services.
- > The Plan expects staff across all disciplines to be able to fully use their training and apply their discipline specific assessment and therapy skills. There is an emphasis on enhanced skills and responsibilities with a greater role for advanced care practitioners, the provision of evidence based therapies by clinicians, and the transfer of care coordination and support roles to NGO mental health staff.

### Key focus areas

As an outcomes based plan, it is envisaged that:

- > services will be planned to the highest quality, are safe, respectful and protect the rights of all who utilise services
- > outcomes reflect what consumers can expect from services, as well as meeting population-based needs. This includes outcome measures that assist individual consumers with their care, clinical staff in monitoring therapeutic and functional outcomes, and administrators in monitoring system performance
- > culturally safe community-based care enables more efficient access resulting in earlier intervention and crisis prevention
- > models of service delivery are inclusive to linking and integrating services wherever possible with resources determined locally
- > every therapeutic encounter aims to be meaningful, validating, engaging and effective, resulting in positive therapeutic outcomes for consumers and reducing hospitalisation and re-admission
- > workforce capability offers the right skills mix whilst acknowledging existing expertise.

## Language

Language used throughout the Plan recognises the diversity and preferences of individuals, groups and communities.

Below are some key terms used and their intended meanings within the context of the Plan:

- > **Consumer or care recipient** – Patients or clients, potential patients or clients and organisations representing consumers' interests.
- > **Carer** – A person who provides a caring and supportive role for their parent, partner, child or other relative or friend who has a mental illness. A person is not a carer just because he or she is a partner, parent, guardian, child or other relative of an individual, or that he or she lives with a person who requires care. Carers can be parents and guardians caring for children and children who care for their parents and guardians. In the context of Aboriginal communities and kinship systems, caring is a collective act with many people helping to care for a single person. Many people looking after family and friends will not recognise themselves as carers.
- > **Aboriginal people** – Throughout the Plan the term 'Aboriginal people' includes all people of Aboriginal and/or Torres Strait Islander descent in South Australia.
- > **Community** – Groups of people with a common interest. Communities can include organisations such as NGOs that represent the interests of health consumers. Some communities may be connected via common health interests, or share the same cultural background, religion or language.
- > **Department for Health and Wellbeing (DHW) services** – includes any service that is operated or commissioned by DHW.
- > **Mental health** – A state of wellbeing where an individual has the capacity, skills and resources to work through adversity, meet their needs and find meaning and purpose in their life.
- > **Mental illness/disorder** – A clinically diagnosable disorder that impacts on a person's cognitive, functional, emotional or social abilities. Mental illness is diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) or the International Classification of Diseases (ICD-10) (WHO, 2011). There are various types of mental illness, including anxiety disorders, depressive disorders bipolar disorder, eating disorders and schizophrenia. Mental illnesses can have different levels of impact and severity.
- > **Mental health issues or concerns/mental ill health** – Thoughts, feelings or behaviours which can impact on a person's mental health and wellbeing and lead to distress and disruption to their lives. Mental health issues can occur with or without diagnosed mental illness.



## 1.2 Background to the development of the Plan

The development of the Plan has considered:

- > the knowledge and expertise gained from the community conversations held during the development of the South Australian Mental Health Strategic Plan 2017-2022
- > the National Mental Health Service Planning Framework
- > workforce modelling
- > population and funding modelling
- > capital infrastructure
- > information technology data systems
- > safety and quality systems and evidence based practice
- > e-health applications
- > key performance indicator development
- > funding sources and resource reconfiguration.

### Mental Health Services Plan Development Governance

A governance structure was established to oversee the development of the Plan, consisting of an interdepartmental executive group to provide high level oversight. A project steering group provided oversight to the work of six project work groups. More information on the governance structure is available in Appendix 1.

### Consultation process

In addition to the membership of the various groups included within the governance structure, consultations also occurred with key stakeholders (see Appendix 2). Several forums were held with consumers and carers and an integrated co-design and co-production process is embedded in the development of the Plan.

### Consultation forums and meetings

Two community forums facilitated by the South Australian Mental Health Commission were held in November 2018 (approximately 60 attendees) and December 2018 (approximately 80 attendees). Key themes from these forums included:

- > personalised care – seeing and supporting the whole person, not treating people as an illness
- > more face to face time to do more caring and listening, for more people
- > having access to a broader range of treatment options – not just medication
- > a greater focus on reducing suicide
- > addressing mental health stigma through training for all staff
- > improving Aboriginal and child/youth specific services
- > having access to safe and comfortable spaces away from the emergency departments
- > better use of technology that supports social connectedness.

Running parallel to these processes were consultation forums with industrial and professional groups held in November 2018, ensuring a comprehensive stakeholder consultation process (see Appendix 2).

Follow up forums for industrial and professional groups and first responders were facilitated in early January 2019, providing a summary of the key themes and priority areas collated by each of the work groups to date and an opportunity to provide feedback on the indicative outcomes being explored.

# 2. Plan overview

## 2.1 Key Themes

The Plan recognises that mental health and wellbeing is everyone's business and that quality mental health care should be available to all people in South Australia. The Plan incorporates a greater focus on community based care, aspiring for improvements in the way that services are delivered. The Plan supports more efficient access to personalised care, earlier intervention and crisis prevention.

### Life course approach

The Plan emphasises service delivery across the lifespan, taking into account the diverse health and social needs during perinatal, infancy, childhood, adolescence, adulthood and older age. It considers how individuals and families can be assisted in meeting their needs, including people and communities at increased risk of mental illness that may require more specialised care and support.

### Therapeutic engagement

When therapeutic engagement is experienced by consumers and carers as meaningful, validating and shaped around their needs, treatment outcomes are positive and there is a reduced need for hospitalisation (Stanley et al., 2018; Benjenk & Chen 2018). How we measure these improvements at an individual and population based level has been a significant focus of the Plan. From a population health approach, such outcomes are not just measured by the absence of illness alone; rather, observations of change are made at social, environmental, physical, cultural, economic and social levels.

### Recovery oriented services

Recovery is a holistic concept requiring services to build effective partnerships that support individuals as they recover, including but not limited to – health, housing, relationships, education, employment, social and recreational needs. The Plan is aligned with the following principles of recovery-oriented mental health practice:

- > *Uniqueness of the individual:* Recovery is not about cure, it recognises inclusion, quality of life and the person remains at the centre of their care and support
- > *Real choices:* Strengths based, empowering the person to acknowledge their skills and make real choices with support
- > *Attitudes and rights:* Actively listening, promoting hopefulness and the protection of human rights and citizenship

- > *Dignity and respect:* Being respectful, helpful, culturally sensitive and challenging stigma and discrimination
- > *Partnership and communication:* Supporting the person's own expertise, valuing their own goals and aspirations and promoting clear communication
- > *Evaluating recovery:* Acknowledging the person's abilities to track their own progress, shaping positive service improvement through individual care and outcomes that indicate recovery.

### Consumer participation and peer support programs

The effective use of peer workers will be a catalyst to the delivery of rights affirming, recovery based services. The Plan expects that all new commissioned services will have a service model that incorporates trained peer workers as an integral component of service delivery. This would extend to all services as they develop and are remodelled during the life of the Plan so that all consumers accessing acute, crisis, rehabilitation and community-based care have access to a peer worker. This includes consumers from culturally and linguistically diverse backgrounds, Aboriginal people, young people, older people and people living in country areas. This will be achieved by setting a new standard for peer workforce involvement that will need to be considered when new budget bids are made or existing services are re-designed.

### Carers

Although carers play a crucial role in supporting people with lived experience, they are not always acknowledged as a true partner in recovery. Carers have told us about the impact of their caring role on their own health and wellbeing, experiencing higher levels of depression and stress associated with the challenging situations they face on a daily basis. Education is a crucial component; enabling carers to understand the mental health condition experienced by the person they care for and developing communication and problem-solving skills to respond appropriately. Mental health services need to include Carer Consultants within their teams to engage with, and support, carers of people with a mental illness.

### Young carers

It is essential to consider the needs of carers under 18 who support their parents or family members with daily activities, whilst also meeting their own education, work and other personal needs. Many children and young people assume a caring role without realising as it is has always been part of their family dynamic.

It is vital that young carers are recognised and supported to help with managing their own mental health and wellbeing and the emotional impact of their caring role.

### Integrated interventions

Maintaining positive mental health requires a holistic approach that encompasses the person's whole of life needs. The delivery of services offered by Commonwealth, State and NGO sectors must be better understood, more easily navigable and capable of building up service capacity and not dividing it. A clearer access pathway into DHW operated services and DHW funded NGO services is required, ensuring that accessibility reflects consumer need.

The Plan supports a more integrated approach that recognises the impact that multiple risks and social determinants can have on the mental health and wellbeing of individuals, their families and the community. A particular focus will be on supporting PHN funded services, providing specialist mental health support in partnership with their staff where needed.

### Social determinants

The Plan takes into account the significant impacts of disadvantage that our most vulnerable people experience day to day and the need to prioritise initiatives that focus on prevention and earlier intervention. The Plan recognises the evidence surrounding inequities in achieving health outcomes, including the impact that disadvantage and adverse events experienced in the early years can have on people's lives.

A social determinants perspective recognises that mental health concerns can be the result of a complex interplay of factors including biological, environmental, cultural, physical, lifestyle and social influences. These social determinants include housing, education and employment, fair and equitable justice, as well as literacy and awareness.

The Plan recognises how social determinants that operate at both an individual and population level can translate to risk or protective factors. Protective factors can include a sense of belonging, connectedness, positive coping strategies and good physical health that may reduce the burden of an existing disorder or prevent one emerging. Risk factors may include poverty and low income, unemployment, homelessness, socioeconomic disadvantage and isolation, all of which can impact and exacerbate mental health problems and illness (Department of Health 2017).

### Equity of access to services

Equity issues will be considered in the commissioning of services, specifically for population groups that currently have less access to mental health services compared with other groups in South Australia.

This includes Aboriginal and Torres Strait Islander people, people in country areas, and people in the Northern suburbs of Adelaide.

Improved access to forensic mental health services (community, prison in reach, and inpatient care) also needs to be prioritised in the commissioning of services during the life of the Plan.

### Supporting the workforce for an improved consumer experience

At the centre of the Plan is the principle that more people with a lived experience of mental illness and their families and carers are partnered with to participate, advocate and be actively engaged in service planning and design, delivery, research, monitoring and evaluation. A critical component of this is supporting a professionalised peer workforce that is embedded in all levels of service delivery. Such actions must be supported by clear governance structures with access to supervision and professional development opportunities. This will be informed by the Lived Experience Engagement Policy that is being developed nationally by the National Mental Health Commission.

### Staff wellbeing

The Plan acknowledges that providing care to people experiencing mental health concerns and various forms of vulnerability and social disadvantage can take an emotional toll. While being in a position to provide care and support to others in need is a privilege, doing so on an ongoing basis can also be taxing at times. Therefore self-care and active measures to improve staff wellbeing are crucial.

All commissioned services will be expected to provide a staff mental health wellbeing strategy as part of funding arrangements. While the nature of that wellbeing strategy will be determined by LHNs and NGO employers, the expectation is that mental health services will be leaders in supporting the wellbeing of their staff, and that this will translate to better services for consumers. Elements will include access to training, education, supervision, staff peer programs, and standards for debriefing and supporting staff after critical incidents or potential vicarious traumatisation.

Training and change management are critical to the implementation of new and remodelled services. It is expected that remodelled clinical services will have a greater emphasis on therapeutic care and NGOs support services will provide more complex case coordination. To deliver this it is expected that both the Department and the LHN and NGO training budgets will need to be re-focused on skill training in these areas.

Given the critical nature of staff wellbeing in the delivery of the objectives of the Plan, commissioned services will be expected to report on both staff satisfaction with employment and wellbeing.

### Aboriginal Mental Health

Access to a full range of culturally safe services for Aboriginal and Torres Strait Islander People will be critical objectives of the Plan. This will be supported by a proposed Aboriginal Mental Health and Wellbeing Centre which will support mental health services as well as providing collaborative care for families in local communities. The Centre will support the training and work of Aboriginal staff in mental health worker and professional roles. This is aligned with the Gayaa Dhuwi (Proud Spirit) Declaration that is central to the Fifth National Mental Health and Suicide Prevention Plan, that seeks to bring together Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing with clinical perspectives, and is supported by Aboriginal and Torres Strait Islander presence and leadership across all parts of the Australian mental health system.

### Effective suicide prevention

The Plan demonstrates a strong commitment to 'Towards Zero Suicide' within our tertiary mental health services. This will be achieved through timely access to care, engagement, safety planning and follow up, and ensuring that people at increased risk of suicide don't fall through the gaps. The Plan will encourage DHW in its commissioning role to support additional capacity for a Towards Zero Suicide strategy to be implemented, and for LHNs to use existing resources to give staff the opportunity to participate in clinical practice improvement initiatives. This would provide a framework for clinicians to review, identify and understand areas of practice that need improvement; design systems that prevent harm and develop strategies for continuously improving processes of consumer care.

The Towards Zero Suicide target of 'zero' reflects the aspiration to prevent all deaths in specialty services (Labouliere et al., 2018). Based on literature reports of 20-30% reductions in mortality when these programs are implemented (and in some settings even greater reductions of over 60% or more) (Mokkenstorm J et al, 2017, Hampton T, 2010), this Plan has set targets for a 20% reduction in suicide deaths in specialist services within the medium term, and a 50% reduction of suicide deaths in specialist services by the completion of the Plan. Such services have high levels of engagement with consumers, consistent use of safety plans, reliable follow up without gaps, and therapies that address suicidal thinking.

### Supporting the health system for an improved consumer experience

To succeed, the Plan will need to solve the current wait time consumers experience in accessing services. Current wait times in emergency departments are a critical issue for consumers who can find the experience distressing. The Plan proposes a renewed emphasis on alternative crisis services and effective community services that intervene early.

## 2.2 Vision, Values and Goals

The Vision of the Plan is based on and supports the overarching vision in the South Australian Mental Health Strategic Plan 2017–2022, and provides the overarching service expectations that underpin the outcomes identified in the Plan. Subsequent measures of success (linked to the Fifth Plan) will be used to monitor and evaluate the Plan over time.

### SA Mental Health Strategic Plan vision:

South Australia is internationally recognised as a resilient, compassionate and connected community that takes a whole-of-person, whole-of-life, whole-of-government and whole-of-community approach to building, sustaining and strengthening the mental health and wellbeing of South Australians in order to grow the state's mental wealth.

#### *Vision of the SA Mental Health Services Plan:*

*The South Australian Department for Health and Wellbeing will commission mental health services of the highest quality, that are effective and safe, uphold human rights, enhance wellbeing and support people to fully participate and thrive in their chosen community.*

### Values

How we do our work drives the safety and quality of our services. The Plan adopts the SA Health Values which provides a foundation for how we describe the productive behaviours we demonstrate ourselves and expect from our colleagues.

If we act consistently with these values, our culture will enable delivery of a contemporary and sustainable mental health and wellbeing system that is of high quality, skilled, and provides care and empathy in every interaction.

Even though a person may enter our services in crisis and at times we may see them when they are not their usual self, our job is to support them to rebuild their life in the community.

Our services will be respectful of consumers individual experiences and perspectives and will not reinforce negative stereotypes with our co-workers or in the community.

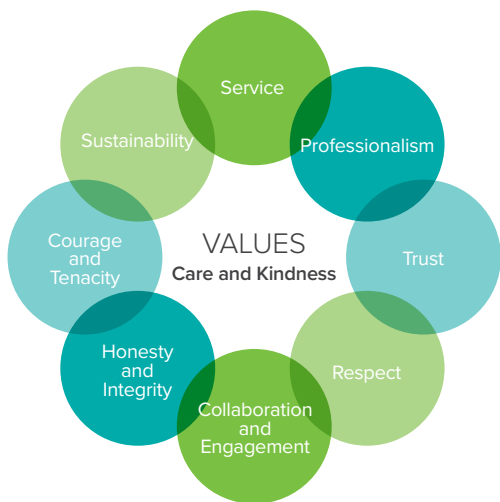


Figure 1: SA Health Values

### GOALS (for Department for Health and Wellbeing commissioned services)

The following high level goals capture the breadth of change and reform based on the consultation for the Plan:

- > personalised care
- > integrated care
- > safe and high quality care.

These three goals are interdependent and action in one area will drive improvements in all other areas.

### Why personalised care, integrated care, and safe and high quality care are the three key goals for the Plan

A person experiencing a mental illness or mental health concerns remains a *whole* person and therefore requires a holistic approach that acknowledges the complex interplay with broader health and social needs. An ecological approach encompassing social determinants of health is critical in supporting more effective outcomes. Mental health for individuals is not isolated from other factors of overall personal wellbeing nor insulated and shielded from wider political, economic, material and social conditions around them.

The ultimate goal of our health system is to deliver high-quality care that is safe and provides a meaningful and therapeutic experience for consumers, their carers and family. Focusing on delivering personalised care will enable services to be successful in achieving better outcomes for people, including consumers and staff; and better value care (Naylor et al., 2016).

### Personalised Care

Personalised care involves supporting people to develop the confidence, skills and knowledge to effectively manage and make informed decisions about their own mental health and care needs. Central to this is ensuring that people are treated with empathy, dignity, compassion and respect in every encounter. It encompasses the person's preferences and wishes in collaborative planning and shared decision making and uses goal setting, planning and evaluation to ensure that services respond to the individual needs of the person.

The personalisation agenda of the Plan has four key elements: setting of personal goals, choice and control, access to high quality assessments and therapies, and the use of technology to complement care.

The focus on goal setting is to ensure that time is spent with consumers and carers to describe their personal goals and that therapies support a person to work towards those goals. Such consumer goals are often related to achieving functional outcomes – to meaningfully participate in the community, to study or to work, rather than clinically defined outcomes.

Choice and control requires that consumers' wills and preferences are considered, not only in the delivery of individual care, but in the way that services are designed. The Plan anticipates that services will be commissioned to provide a menu of best practice interventions that are available for consumers to choose from. Services are to be designed and commissioned to deliver these interventions at a time and place that best meets the person's needs.

Technology will be commissioned to supplement face to face care, to support self-management, care planning and engagement with the service. Where possible, the control of information will rest with consumers, and carers will have access to necessary information to fulfil their roles.

To deliver personalised care, consumers must be heard, and in many situations this will require advocacy to ensure that the best care is delivered. The sources for this advocacy are broad and variable, depending on the issue and context. It may involve self-advocacy from consumers and carers, advocacy from peer workers, and by mental health staff. While advocacy can be delivered from many sources, the Plan proposes an expansion of the number of peer workers who can support consumers to identify and express their will and preferences.

Traditional measurement and evaluation in mental health has commonly focused on activity and clinical outcomes, with limited focus on what people and carers consider as important (Procter et al., 2017).



Designing and measuring personalised care outcomes – such as level of independence, quality of life, social connectedness, being active in decision making processes surrounding treatment, staying active in work or study (either full-time or part-time) – can be complex. This can be achieved through personalised outcome measures that record change in attaining specific goals, and consumer and carer satisfaction.

Effective personalised care will seek to provide support early in the course of distress and/or in the emerging mental illness and deliver optimum therapeutic and rehabilitation outcomes for individuals. A particular focus will be given to voluntary treatment where possible to reduce the risk of coercion.

Consumers will not be restricted to geographic catchment areas when deciding which service to access. The plan supports the idea that people can vote with their feet to present at the service that best meets their needs based on service reputation even if that means crossing a LHN border.

## Integrated Care

Comprehensive mental health care, incorporating promotion, prevention, early intervention, treatment and rehabilitation will be integrated with other health, social, and community services.

With increasing demand for services, it is not possible for DHW funded services to respond to population need alone. There must be a priority focus on integrated strategy that links with services across both State and Commonwealth funded programs.

Studies have shown that people with serious mental illness live between 10 and 36 years less than the general population (Victoria Institute of Strategic Economic Studies 2016). This is in part due to preventable physical illness, highlighting the need for mental health and physical health care to be better integrated.

Integration will also be enhanced through common consumer access and referral points wherever possible. Extensive community-based primary mental health services are now funded by PHNs. Shared access points for services mean that consumers can present to one point and connect to the right level of service for their needs (primary and secondary through PHN commissioned services, and tertiary through DHW commissioned services).

Many consumers and families find it difficult to reach our specialist clinics, so the proposed embedding of staff in other services such as schools, child protection services, youth health, homelessness services and community aged care could improve access and deliver a more collaborative response.

Integrated care can also be achieved through a shift in the roles of NGOs and Government providers. The Plan proposes a fundamental change to the contracting of NGO services post the National Disability Insurance Scheme (NDIS) to improve coordination and integration. These changes would include:

1. a new NGO service access point for consumers and referrers, and a removal of the requirement that consumers of state funded NGO services be registered services of a state clinical service first. Access to NGO services will be based on need and whether or not a consumer meets the criteria for the NGO service;
2. NGOs would provide case management and coordination of care, transferring this expectation for many consumers from clinical services which currently undertake this role. For people with complex needs NGOs will provide case management; while government providers will deliver high quality clinical services assessment, therapies and interventions to assist treatment and innovation;
3. NGO funding would be divided into two programs – an acute crisis care stream offering short term at home services and residential crisis support, and a psychosocial rehabilitation stream.

The immediate priority for DHW will be re-establishing the roles of state funded NGOs post the implementation of the NDIS, with new NGO access points and redefined roles in crisis care and support for all clients and ongoing psychosocial rehabilitation for non-NDIS eligible clients. Home-based support and supported accommodation managed by the NGO sector will be available for people who are not eligible for a NDIS service.

A pre-qualified provider list of NGOs will be established and organisations on this list will become partners in co-design and service model development.

Two possible funding approaches will be trialled within the life of the Plan for psychosocial rehabilitation services – an individualised funding model that provides choice and control to the consumer and a capitation model that provides a single payment to a provider to deliver a comprehensive range of support and clinical services to consumers who choose to enrol with a provider. Linked to this second approach will be the commissioning of a comprehensive service model for NGO mental health services which seeks to provide services in a one stop shop modelled on services developed in the aged care and general health sector. This NGO service would provide mental health clinical and support services that would be both home visiting programs and centre based services.



Such services would also deliver some physical health screening and services for consumers. Consumers could elect to receive their services in the usual way from existing providers or enrol in a comprehensive service model.

In the first two years of the Plan, new service models will be developed for the provision of NGO services in partnership with consumers, carers and NGOs. NGOs providing crisis services would be funded directly by DHW based on activity with clinical outcome, safety and performance measures. For psychosocial rehabilitation services it is expected that an individualised funding model would be considered as part of the joint planning to provide consumers with choice and control of providers and services.

NGOs offering comprehensive services will be encouraged to provide allied health and nursing services in addition to traditional psychosocial support services. This approach aligns with existing service delivery by NGOs in physical health care that already provide both psychosocial and clinical services.

### Safe and High Quality Care

It is recognised that more work is needed to keep consumers safe from avoidable harm in our services. This requires better engagement of frontline staff and consumers and carers in clinical practice improvement projects, upholding national standards, and improving measured quality outcomes across our services<sup>1</sup>.

Safety and quality and human rights are mutually supportive and overlap. Attributes of a positive safety culture in an organisation – ones that are proactive in improving services, and are focussed on quality and safe service provision, can also uphold human rights recognising individual's dignity, respect and autonomy.

This Plan has three broad approaches to safety and quality:

- > The first is to inextricably link the safety and quality agenda in this plan with human rights. This drives us to safer systems that respect the individual. Empowerment of consumers and carers is a rights-based strategy that also improves therapeutic outcomes by ensuring that the right therapies are delivered and potential harm is identified and addressed. The reduction of coercion is a goal of the Plan, aspiring to reduce the rate of community treatment orders and inpatient treatment orders without risking consumer, staff or community safety.

- > The second is the application of improvement science to mental health care. A key element of this is the use of continuous practice improvement techniques by front line staff and consumers to redesign and improve clinical processes. Responsibility for leading such work rests across the system, but it is anticipated that the soon to be formed Commission on Excellence and Innovation will take a significant role.
- > The third area relates to the design and overall performance management of the system. As noted earlier, key elements of system design and organisational culture can influence safety and prevent suicide (Kapur et al, 2016). It is incumbent in the implementation of the Plan to ensure that key elements of our system are not only in place, but are also effective and consistent in their delivery. This includes areas such as 24 hour crisis services, home based treatment, and effective intervention for people with drug and alcohol co-morbidity. Services must deliver evidence based interventions based on clinical guidelines.

Efficiency is also a component of safety and quality. Just as it is unacceptable to underfund and understaff a service, overfunding and overstaffing a service is also a quality problem due to the opportunity costs created when other potentially valuable services cannot be funded. One area of focus for the Plan is reducing administrative demands on community mental health staff by creating more efficient systems and the reallocation of some coordination and support tasks to NGO staff and peer workers. Another is the use of earlier intervention services to prevent people becoming so unwell that more intensive inpatient treatment is required.

The Plan focuses on clinical systems rather than capital developments. In some respects it is easier to develop buildings than it is to develop sustainable high quality clinical systems and cultures. The Plan proposes that outdated infrastructure be modernised in the long term including James Nash House, Woodleigh House, the child and youth mental health ward at the Women's and Children's Hospital and older persons facilities. Other units will be progressively reassessed, as both community clinics and inpatient settings may need refurbishment to meet modern standards and the delivery of contemporary, safe and least restrictive care.

<sup>1</sup> More details of safety and quality initiatives are in the relevant sections in this plan.

## 2.3 Key initiatives

To succeed, the Plan will need to solve the current wait time consumers experience in accessing services. Current wait times in emergency departments are a critical issue for consumers who can find the experience distressing and would prefer community-based services. To do this, the Plan will have a renewed emphasis on alternative crisis services and effective community services that intervene early.

### Crisis response model

The Plan proposes new services based on a crisis response model that seeks to assist and support people in distress or experiencing illness relapse. One component would be a revamped Mental Health Crisis and Support Telephone and Web service with the ability to dispatch mobile crisis teams that provide timely, supportive intervention in the metropolitan area, with similar functions available using on-call models in larger rural centres, and telehealth support to other health professionals in regional and remote areas.

### Urgent Mental Health Care Centre

An Urgent Mental Health Care Centre is a service component that is a part of the Plan but not currently delivered. This would be a standalone centre in proximity to a major hospital, but not part of the hospital. Urgent services would be provided to consumers who walk in or ambulance referrals up to triage category 3 (Urgent, requiring assessment and treatment within 30 minutes). Police referrals with prior case discussion would also be accepted.

This component is expected to be successful, but would be initially trialled with one centre in the CBD. A person seeking crisis care could attend this centre instead of emergency departments to access peer support, professional assessment and treatment. It is expected that while new staffing would be needed for the first centre, they would also be supported by the mental health teams currently assigned to emergency departments, with the expectation that demand will shift, leaving staff remaining in the ED to predominantly manage behavioural emergencies either caused by mental illness or related to co-morbid drug and alcohol presentations. The working relationships between the Urgent Mental Health Care Centre and emergency departments will be defined as part of the development of the model of care and operational protocols, with the expectation that models will support greater staff mobility across the two services types as demand shifts from the emergency departments to the Urgent Mental Health Care Centre over time.

### Comprehensive Mental Health Crisis Support Telephone and web-based service

A comprehensive Mental Health Crisis Support Telephone and web-based service is proposed to replace current triage models. International best practice examples use what is described as the 'Air Traffic Control' model, where an operator provides therapy, support and follows a consumer's progress, in the same way an air traffic controller follows an aircraft for which they are responsible.

Technology in services would drive the allocation of resources to both the call centre and to emergency mental health mobile teams with the expectation that critical time frames for crisis services are met. This would include a minimum 95% call response rate within 30 seconds for emergency mental health calls, and a 60 minute response rate for emergency life threatening crises in the community in the metropolitan area (alternative strategies to provide a responsive service would be delivered in country).

### Mobile crisis teams

It is expected that Mobile teams would go 'to the person' who needs support, care, and follow-up, and be available 24 hours per day. In the first instance, collaborative models with ambulance services and police would be trialled. Ultimately within the life of the Plan, two person mobile crisis teams would be trialled which combine a health professional and a peer worker, similar to models used in United States (US) cities, with an expectation that if this is successful it becomes the future model of operation for South Australian mental health crisis services.

### Safe Haven Cafe

The Plan will also support services who wish to develop a related crisis support initiative based on the successful United Kingdom (UK) model: the Safe Haven Café (Whitfield 2015). Staffed by peer support workers, clinical staff and volunteers, people in crisis will have a safe place to attend for support. Such centres in the UK have reduced emergency department demand and one has been opened by a hospital in Victoria, Australia (Health Victoria 2018).

### Acute Behavioural Assessment Units

Increasing reliance on our emergency departments to provide behavioural assessment and treatment is not sustainable for the health system and its staff. There will continue to be a small number of critical emergencies that will require hospital attendance. The Plan proposes the future establishment of Acute Behavioural Assessment Units that involve collaboration between emergency medicine, toxicology, drug and alcohol services and mental health services.

Such units could potentially operate in the three major emergency hospitals in Adelaide, and a telehealth supported Virtual Acute Behavioural Assessment Service could assist rural hospitals to administer safe protocols to manage people with significant behavioural disturbance secondary to drug and alcohol use, mental illness, or a combination. Such units would better address the methamphetamine problems troubling emergency departments.

### Towards Zero Suicide initiative

The Plan supports Initiatives that improve the safety and quality of mental health care that goes above and beyond the safety and quality work that LHNs and NGOs would usually undertake. Internationally it is recognised that Continuous Practice Improvement initiatives that empower frontline staff and consumers and carers to design new safe systems, measure outcomes, and then further improve and develop systems are most effective. As noted, the Plan proposes a 'Towards Zero Suicide' initiative, aiming to reduce mortality by suicide in our tertiary services by at least 20% or more in three years, and a target of 50% at five years. This would correspond to at least 20 lives saved per year.

### Least restrictive practice

Reductions in coercion and compulsion are key goals that will be achieved without putting consumers and community at risk. The use of community treatment orders (CTO) will be minimised with a target to be set based on the lower use of coercion and CTOs in comparable international jurisdictions. A similar target will be set to reduce the number of involuntary admissions for consumers with a mental illness (to ensure that this target is reasonable and achievable, it will not include the use of coercion for drug intoxicated consumers requiring restraint). There will be a renewed emphasis on the reduction and elimination, where possible, of restrictive practices in inpatient and residential settings.

### Partnerships with Primary Health Networks

The Plan emphasises the need to commission state government services that are integrated with services commissioned by the Commonwealth Government through Primary Health Networks. Wherever possible, consumers will experience a connected service system, with plans to explore common entry points for youth mental health services, and arrangements across age groups for collaborative programs and clinics, where specialist staff can support PHN staff.

### Capability Based Flow

The Plan supports a new approach to implementing flow, properly using the stepped system and maintaining system safety. This concept is described in the Plan as Capability Based Flow. Flow of consumers from each part of the system to the next will be determined by the actual capability of service components, not the theoretical capability from the literature. For example it is known that flow from inpatient units to home care or to residential step down care, frees beds, enables new admissions from emergency departments or the community. There is a risk that consumers can be discharged while unwell on the assumption that a receiving service will be able to deliver necessary care, not actual capability. The proposed Capability Based Flow model would be trialled at the local level to assess service capability of its model of care, resources, culture, staffing and outcomes.

## Overlapping Transition Points

Transition points based on age represent a risk for engagement (or disengagement) with services and for safety. It is also necessary to ensure that people receive appropriate care. During the life of the plan the following transition points will be used:

Child and Adolescent Services	0 – 18 years	New referrals routinely to age 16, but can be accepted up to age 18 when CAMHS is the most appropriate service.  Adolescents can stay with the service until age 19 or in some cases beyond if in their interests to do so.
Youth Mental Health Services	16 – 24 years	New referrals for this age group will predominantly go to the Youth Team, unless it is in the interests of the young person to attend a subspecialist adult program.
Adult Mental Health Services	18 – 70	Can accept referrals for people aged 18 – 24 via Youth Mental Health Services intake.  Receives all referrals for people aged 24 – 70.  People aged 60 – 70 with dementia may be referred to the older persons service, while people with mental illness will be managed by adult services.
Older Persons Mental Health Services	70 onwards.	Routinely accepts all referrals over age 70.  Can accept referrals for consumers 60 – 70 with dementia or who are physically frail from adult services.

The transition point for youth is also subject to further planning following a review of services. In particular, whether services should extend to 21 or 24. Regardless of who provides the service a common intake point for 12-24 year olds will be designed to direct people to the service that will best meet personal, developmental and clinical needs, and provides the correct intensity of service in a stepped model.

## State wide application

It is expected that Outcomes from the plan will be delivered across the state. While many strategies are similarly applicable regardless of location, implementation of some initiatives in rural and remote regions will vary. As long as either a service or function is accessible to communities, local planners and communities are best able to make decisions about how it is delivered. An example is the provision of designated 'functions' in lieu of a stand alone service. A small rural centre is unlikely to have a stand alone urgent mental health centre, but similar professional and peer services could be made available from existing facilities when required using similar best practice clinical pathways and principles as used in a metropolitan centre. Likewise Crisis Retreat centre *functions* might be delivered from community or regional hospital buildings in some rural locations. Such decisions would be locally made.

# 3. Context

## 3.1 International perspectives

### Human Rights

The Plan is underpinned by a human rights-based approach that recognises and respects a person's civil, political, cultural, economic and social rights which can be upheld through access to health care, housing, education and work, among other measures. The Plan must also uphold civil and political rights which can be achieved by minimising the use of coercion, amongst other steps. The design of services can influence the need to resort to compulsory treatment. The Plan aims to significantly reduce the use of community treatment orders and inpatient treatment orders, while maintaining consumer and community safety. This includes promoting the following principles derived from the Convention on the Rights of Persons with Disabilities (United Nations 2006):

- > respect for individual autonomy including the freedom to make one's own choices, and be independent
- > inherent dignity of the person
- > accessibility of services and resources
- > equality of opportunity
- > full and effective participation in society
- > non-discrimination
- > acceptance of persons with disabilities as part of human diversity
- > gender equality
- > respect for the evolving capacities of children with disabilities
- > respect for the right of children with disabilities to maintain their identities.

Human rights are inter-related and inter-dependent. An integrated approach across health, education, employment, housing, human services and other sectors is essential.

*'For any mental health system to be compliant with the right to health, the biomedical and psychosocial models and interventions must be appropriately balanced, avoiding the arbitrary assumption that biomedical interventions are more effective.'* (United Nations 2017)

### The World Health Organisation (WHO)

The WHO encourages the implementation of mental health community-based services to encompass a recovery-based approach with an emphasis on supporting individuals to achieve their aspirations and goals. Key elements of the approach include:

- > listening and valuing a person's own understanding of their condition and the impacts on their life
- > listening to the persons view of what helps them in recovery
- > working with people as equal partners in care. This includes enabling people to have a choice regarding treatment and therapies, and choice on care providers
- > using peer workers and peers supports, who can provide mutual learning and encouragement, a sense of belonging, and knowledge from lived experience (WHO 2013).

WHO's major mental health initiatives include: Preventing suicide: A global imperative (WHO 2014) and the Comprehensive mental health action plan 2013–2020 (WHO 2013). The four major objectives of the latter include:

- > strengthen effective leadership and governance for mental health
- > provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- > implement strategies for promotion and prevention in mental health
- > strengthen information systems, evidence and research for mental health (WHO 2013)
- > the strategic approach to preventing suicide requires work to increase public health awareness of the impact of suicide and suicide attempts. It is important that we lift the priority of suicide prevention within public health planning and action. It is also essential to support the development or strengthening of comprehensive suicide prevention strategies using a multi-sectoral public health approach (WHO 2013).

The goals and actions of the Plan are consistent with these international priorities.

## 3.2 National perspectives and outcomes

### National Policy Context

The key National context documents are:

- > National Mental Health Policy 2008 (Department of Health 2009)
- > Fifth National Mental Health and Suicide Prevention Plan (Department of Health 2017)
- > National Mental Health Service Planning Framework (Department of Health 2017).

The role of the *National Mental Health Policy* is to provide a strategic framework for guiding mental health reform and service delivery. The vision, aims and key policy actions of the national policy have provided direction for the development of national, state and territory mental health plans for the last ten years.

Recognising that there have been many changes to national and other funding and service delivery arrangements in the last ten years, such as the NDIS, Australian governments, through the Fifth Plan, have committed to renew the National Mental Health Policy. Work on this is currently underway.

### Fifth National Mental Health and Suicide Prevention Plan

The Fifth Plan was endorsed by the Council of Australian Governments on 4 August 2017 and published in October 2017. The Fifth Plan establishes a national and local approach for collaborative government effort from 2017 to 2022 with eight Priority Areas:

**Priority Area 1:** Achieving integrated regional planning and service delivery.

**Priority Area 2:** Suicide prevention.

**Priority Area 3:** Coordinating treatment and supports for people with severe and complex mental illness.

**Priority Area 4:** Improving Aboriginal people's mental health and suicide prevention.

**Priority Area 5:** Improving the physical health of people living with mental illness and reducing early mortality.

**Priority Area 6:** Reducing stigma and discrimination.

**Priority Area 7:** Making safety and quality central to mental health service delivery.

**Priority Area 8:** Ensuring that the enablers of effective system performance and system improvement are in place (Department of Health 2017).

*Priorities of the Fifth National Mental Health and Suicide Prevention Plan (Department of Health, 2017)*

Further national work is being undertaken on a number of actions including the development of a National Suicide Prevention Plan and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Plan.

The Fifth Plan has identified 24 national key performance indicators. Progress on most of these performance indicators is reported on at a national level with a small number being the responsibility of state and territory jurisdictions.

The Fifth Plan also recognises and relates to the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (Department of Health and Ageing 2013) as well as state and territory mental health and suicide prevention plans. The Fifth Plan assists in providing context and coordination, highlighting areas where a national approach is required and where state, territory and national governments can best work together to improve capacity and outcomes.



The Fifth Plan emphasises partnership and coordination, with an expectation that Commonwealth funded Primary Health Networks, and state funded local health networks will develop regional integrated mental health plans.

### National Mental Health Service Planning Framework

The use of NMHSPF will assist in undertaking and supporting integrated planning and service delivery which are requirements of the Fifth Plan. Further information on the framework is available in section 3.

## 3.3 State Context

### South Australian Mental Health Strategic Plan 2017 - 2020

In 2017, the South Australian Mental Health Commission published the South Australia Mental Health Strategic Plan 2017 – 2020, proposing a series of strategic directions which focus on improving mental health and wellbeing outcomes for South Australians. The development of the Strategic Plan involved extensive consultation and contributions from over 2,270 people across the South Australian community. The Mental Health Services Plan has been a collaborative effort between the Office of the Chief Psychiatrist and the Mental Health Commission, building on the vision and direction provided by the Strategic Plan and the upcoming South Australian Health and Wellbeing Strategy 2019 – 2024.

### State Policy Context for Mental Health Services

The policy context for mental health services is underpinned by a range of policies and strategies at the national and state level.

*The Health and Wellbeing Strategy 2019-2024* (Government of South Australia 2019) is a state-wide, system-level strategy which aims to meet future health challenges. It will focus on South Australia's health priorities but includes initiatives that look to adopt a longer term perspective to 2030. The strategy will aim to ensure that DHW is responsive to the changing health needs of our community and is able to position itself to harness the opportunities provided by innovation and technology in the future.

*The SA Health Strategic Plan 2017-2020* (SA Health 2017) projects a vision for the Department for Health and Wellbeing and sets priorities and a framework for planning and decision making.

### State Legislative Context

The objects of the *Mental Health Act 2009* that provide the legislative basis for the treatment, care and rehabilitation of a person with a mental illness are:

- (a) to ensure that persons with severe mental illness—
  - (i) receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible; and
  - (ii) retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services; and
- (b) for that purpose, to confer appropriately limited powers to make orders for community treatment, or inpatient treatment, of such persons where required (s6).

The Plan ensures that these services are available and that rights are protected.

Recent 2016 amendments to the *Mental Health Act 2009* include two new guiding principles:

- (ab) mental health services should meet the highest levels of quality and safety;
- (ac) mental health services should (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory (s7) (The Plan focuses on rights, safety and quality and implements the requirements in the Act.)

The Minister's functions, the Chief Executive's functions and those of the Chief Psychiatrist interact, as do the provision of services, quality improvement and safety and quality under both the *Mental Health Act 2009* and the *Health Care Act 2008*.

Other key legislation that the Act has a relationship with includes: *the Guardianship and Administration Act 1990*; *South Australian Civil and Administrative Tribunal Act 2013*; *Carers Recognition Act 2005*, and the *Advanced Care Directives Act 2013*.

### 3.4 Safety and Quality Standards

Safety and quality are critical underpinnings of Australia’s health system. A safe health system is one that decreases or avoids potential or actual harm to consumers. A quality health system is one that provides the right care and is able to improve health outcomes for consumers. The National Safety and Quality Health Service Standards (second edition) state that safety and quality in healthcare means there are systems and processes in place to actively maintain and improve the reliability and quality of consumer care, as well as improve consumer outcomes (ACSQHC, 2017).

#### Commission on Excellence and Innovation

The SA State Government is establishing a Commission on Excellence and Innovation in Health, with the purpose of providing ‘leadership and advice within DHW and the Government on clinical excellence and innovation’ (SA Health, 2019). The commission’s role will be to ‘provide leadership and advice on clinical best practice with a focus on maximising health outcomes for consumers, improving care and safety, monitoring performance, championing evidence-based practice and clinical innovation, and supporting clinical collaboration’ (SA Health, 2019).

#### Statutory Role of the Chief Psychiatrist

The Office of the Chief Psychiatrist (OCP) assists the Chief Psychiatrist to undertake their statutory role established under the *Mental Health Act 2009* which includes the function ‘to promote continuous improvement in the organisation and delivery of mental health services. A guiding principle in the *Mental Health Act 2009*, 7 (1) (ab) is for the Chief Psychiatrist to be guided by the principle that ‘mental health services should meet the highest levels of quality and safety’. This role is reflected in the structure and functions of the OCP.

#### Relevant Safety and Quality Frameworks

The Institute for Healthcare Improvement (IHI) and Safe and Reliable Healthcare (SRH) worked together to develop the ‘Framework for Safe, Reliable, and Effective Care’ or the Framework (Figure 7) (Frankel et al., 2017).

Engagement of consumers and their families is at the centre of the Framework, recognised as contributing to creating safe, reliable and effective care (Frankel et al., 2017). The framework can be used as a guide for health services and offers a way of evaluating how well a service is performing in terms of applying the different principles and concepts within the Framework. It provides a way of conceptualising all the necessary components required to achieve safe, reliable and effective care at the strategic and operational levels (Frankel et al., 2017).

The framework will be used to guide the implementation of the Safety and Quality elements of this plan. The framework is consistent with quality activities across DHW and the Office of the Chief Psychiatrist including the Chief Psychiatrist Inspection Protocol (OCP 2019).

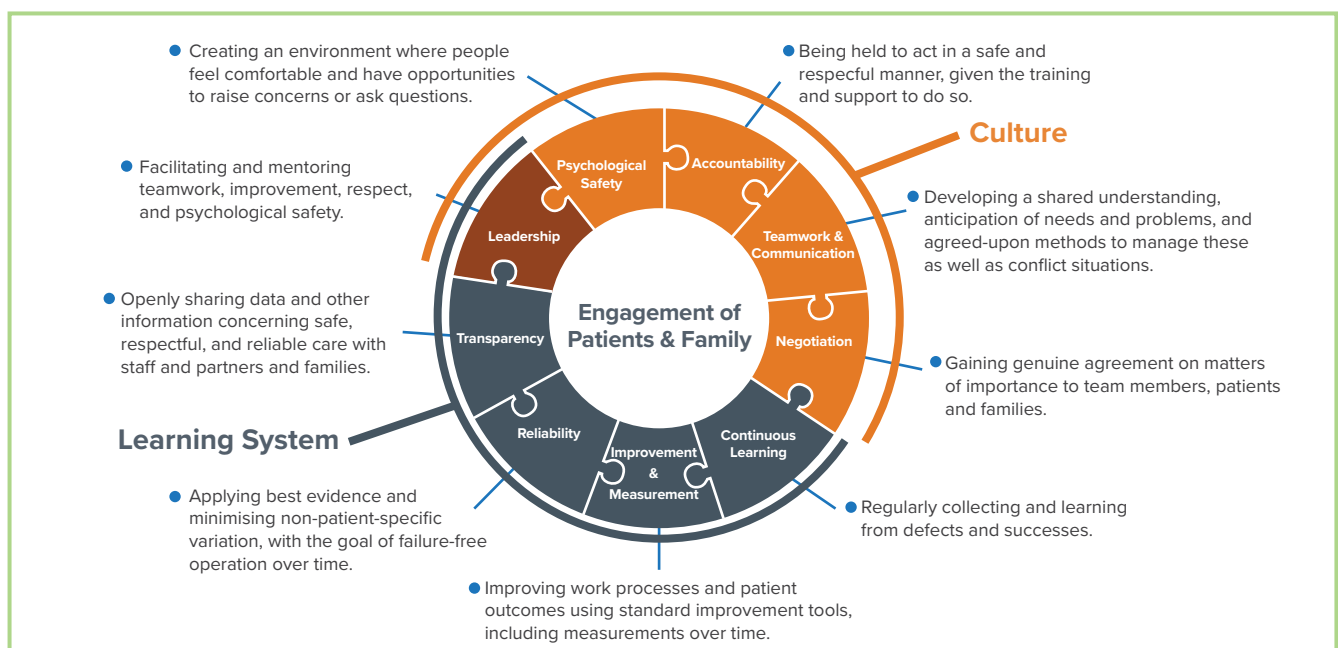


Figure 7: (Frankel et al., 2017).

## National Standards

Accreditation is an important contributor to safety and quality improvement in DHW (SA Health, 2017). Public health services in SA are accredited against the National Safety and Quality Health Service Standards (NSQHSS) (ACSQHC, 2017). The primary aim of the NSQHSS is to ensure minimisation of harm for the public and improve the quality of health services. The NSQHSS principles and expectations are underpinned by the notion of person-centred care.

The second edition of the NSQHSS was released in November 2017, expanding the first edition to include the following: mental health and cognitive impairment, health literacy, end-of-life care, and Aboriginal people's health (ACSQHC, 2017).

In South Australia, non-government agencies who are not accredited against the NSQHSS are accredited against the National Standards for Mental Health Services (NSMHS) which were first made available in 1996 and subsequently updated in 2010. These standards were intended to be applied across mental health services, including public, private and community services (ACSQHC, 2014). With the current use of the ACSQHC by government health services who no longer use the NSMHS, the NSMHS remains authoritative reference point on quality mental health care for use by those organisations not subject to the NSQHSS (The Fifth Plan, Action 22).

Minimum safe care and treatment standards shall be maintained by all mental health services and monitored through an ongoing program of Chief Psychiatrist Inspections (Chief Psychiatrist Inspection Protocol) and complimented by nationally recognised third party accreditation of mental health services.

## Performance Accountabilities Framework

Mental Health Services will use the South Australian Performance Accountabilities Framework which is currently being updated by the DHW. This sets out the framework within which DHW monitors and assesses the performance of public health services in South Australia. It includes the performance expected of health services to achieve levels of health improvements, service delivery and financial performance as set out in their Service Level Agreements (SLAs).

## Improvement science

Improvement science is fundamental to realising the continuous improvement of mental health services. It has been defined with regard to 'the methods to promote the systematic uptake of clinical research findings and other evidence-based approaches into routine practice and hence improve the quality and effectiveness of health care' (Eccles 2006). It seeks to focus attention on the achievement, accomplishment and execution of translation: of supporting the effective and rapid adoption of research findings into policy and practice (Braithwaite J, Marks D & Taylor N 2014).

Mental health services will ensure their workforce is skilled in contemporary Clinical Practice Improvement Methodology, with training and support being available to all staff and consumers and carers involved in service design.

Data, information and measures of success are key features of Clinical Practice Improvement. Identification and evaluation of mental health service opportunities for improvement requires access to real-time data, information and measures through information systems.

This work will be supported through existing clinical governance processes in LHNs. It will uphold the rights of consumers of health services as set out in the Health and Community Services Complaints Commissioner's Charter (Health and Community Services Complaints Commissioner 2011) that include rights of access, safety, quality, respect, and rights to information, participation, privacy and the right to complain.

## 3.5 Measuring future outcomes

The mix of commonwealth and state mental health funding arrangements currently in place can be complex to navigate, particularly where legacy/historical considerations are factors. Having systems in place to collect and report on data in a timely manner is a critical part of improving the collective real time knowledge and understanding of individual mental health and wellbeing. This extends to the role of data to assess and plan population based needs, assessing the effectiveness of current interventions, measuring outcomes, understanding service demands and innovating ways to improve and maintain mental health for people across South Australia.

Over the past decade, per capita funding for non-hospital based mental health services has increased and funding for hospital-based mental health services has been stable. However, it remains unclear whether this overall increase in funding has generated an improvement in outcomes for people with mental illness in our community.

### Mental Health Indicators

As well as using Outcomes described in section 4, an updated list of clinical indicators will be collected based on national and state priorities. The full list of indicators is in Appendix 3.

#### Current Mental Health Indicators – Summary

- > Average Length of Stay:
  - Acute
  - Intermediate Care Centres
  - Non-Acute
  - Residential
- > 28-day readmission rate
- > Admitted patient acute Occupancy
- > Length of Stay over 35 days
- > Emergency Department Visit Time (Hours)
- > Emergency Department Waiting Time for Admission
- > Referral Source
- > Residential OPMHS Occupancy
- > 7 day pre-admission contact rate
- > Post-discharge 7 day follow up
- > Community Contacts
- > Legal Order Compliance
- > Your Experience of Service surveys (consumer measure of their impressions of the care they are provided)

## Current gaps and inefficiencies

- > Current lack of a comprehensive and efficient reporting system. South Australia remains the only Australian jurisdiction that does not report all Mental Health data under a single state-wide identifier.
- > Accessing and reporting on data with the current system is time and resource intensive.
- > The ageing CME software can result in difficulties with work flow and data entry, system slowness and duplication of data entry, impacting on time for direct consumer care.
- > The current Mental Health Care Plan is resource intensive to administer and needs revision.
- > Fragmentation between the current Mental Health Clinical Information Systems (CBIS, CCCME) and other reporting systems including the Safety and Learning System (SLS).
- > Current National dataset gaps
  - Mental Health NGO Establishments Data Set
  - Carer Experience of Care survey
  - Living In the Community Questionnaire (LCQ).
- > Lack of routine system-supported method of calculating Cost per Bed Day and cost per Community Treatment Day.

## Future requirements

- > Single data warehouse that enables better linkages between different data elements.
- > An interface between Mental Health Clinical Information Systems and Emergency Departments.
- > Integrated system for Metropolitan and Country, inpatient, residential and community.
- > An interface with other services for current consumers:
  - General Practitioners
  - Primary Health Networks
  - Non-Government Organisations
  - Health Services
  - Prison Health Services.
- > Improved capacity for recording and reporting on referral pathways.
- > Ability to efficiently record and report on the number of Forensic Consumers in EDs and other inpatient units.
- > Improved capacity to record and report on clinical outcomes (NOCC & HONOS); Risk Assessments; Mental Health Care Plans.
- > Improved mechanisms for measuring and reporting on consumer and carer outcomes, including Your Experience of Service (YES) and Carer Experience (CES) surveys.

- > Improved capacity to record and report on Fifth Plan requirements regarding physical health and suicide.
- > Improved capacity to record and report on Community Mental Health Service data, including the number and type of contacts and length of episode.
- > Improved capacity for recording and reporting on demographic information, including:
  - employment
  - housing
  - education
  - physical health
  - country of origin
  - language and Cultural background, including use of interpreters.
- > Improved capacity to record and report on access to specific therapies.
- > Revision of the Mental Health Care Plan - use of technology to enable care plans to be efficiently developed in partnership with consumers in a more engaging and meaningful way.
- > Activity Based Funding classification development.

The current mental health system contains a range of out-dated information systems. It is expected that technology will support the plan – ranging from affordable app based solutions and other platforms that link primary care and specialist services. Consideration is already being given to updating the current electronic medical record. Decisions will need to be made regarding whether to improve the interface of the existing system, or to move to other enterprise wide systems used across health. A Mental Health Information Technology Plan will be developed within Health that will be informed by the Mental Health Services Plan.

## 3.6 Supporting people who are at increased risk

It is important that all people have access to appropriate mental health care when it's needed, but some people and communities may be at higher risk of experiencing mental health problems and require a more targeted response. These groups may (but do not necessarily) include:

- > Aboriginal people
- > perinatal, infants, children and their families
- > young people
- > older people
- > people from CALD backgrounds
- > people living in isolated rural areas
- > veterans and first responders
- > people within correctional services or forensic mental health settings
- > young people in the youth justice system
- > gender and sexually diverse people
- > people with specialist mental health care needs
- > people with a co-existing physical disability
- > people with substance use and addiction concerns
- > people with co-existing chronic health conditions
- > people experiencing other forms of social exclusion and disadvantage (such as homelessness, unemployment, poverty, domestic violence).

It is critical that people and communities who are more at-risk have timely access to mental health care that is shaped around their diverse needs and preferences, taking into account the health and social needs at all stages of the life course.

In addition, during the life of the Plan a series of Inclusion Standards will be developed. These standards will describe the values, attitudes, knowledge and skills required to provide evidence-based care. Without tangible standards there is a risk of platitudes being expressed, whereas practitioners are needed with contextual understanding and specific assessment and therapy skills to address the clinical needs of different population groups.

Noting the risks of suicide faced by these population groups, work in this clinical area will need to interface with broader community work in the area of suicide prevention.

### Aboriginal people

Mental illness is perceived very differently within Aboriginal communities and is impacted by trauma arising from the Stolen Generations, dispossession and disconnection from land, culture and community, as well as social discrimination, stigma and exclusion. These factors need to be taken into account in order to support better access to culturally appropriate mental health support:

- > Aboriginal view of health (including mental health), whereby health can be seen as a holistic concept viewed in terms of individual and family social and emotional wellbeing
- > the impacts of cultural misunderstandings, racism and intergenerational trauma
- > language barriers and misunderstanding which can lead to fear and confusion
- > extreme imbalance of power due to history and intergenerational disadvantage.

South Australia has the second highest Aboriginal suicide rate of all jurisdictions behind the Northern Territory. Aboriginal people also die by suicide at younger ages than non-Aboriginal Australians, with the majority of suicide deaths occurring before the age of 35 years (AIHW 2018; Department of Health 2017).



The incidence of suicide is 30 per cent higher in regional/rural areas, whilst in remote areas it is twice as high. When compared with those in major cities, Aboriginal people in rural areas experience a 10% higher rate of mental health hospital admissions and 100% higher rate of drug and alcohol issues and intentional self-harm. Many people are not able to access prevention, primary care and early intervention services due to lack of availability. Therefore health issues are detected at a later stage of development and illnesses are more advanced. The Plan proposes an Aboriginal Mental Health and Wellbeing Centre with a metropolitan and rural location to support cultural safety in services across the state.

### Perinatal, infants, children, young people and their families

Mental disorders are one of the largest causes of disability and health burden in children and adolescents. The experience of disorder can impact on a child's learning and development, and can also impact significantly on family life. Many adults with mental disorders experience symptoms or issues in childhood or adolescence, suggesting that prevention and early intervention are important approaches to reducing the burden of mental illness through the life course (Lawrence et al., 2015).

Awareness has increased regarding the risk of mental health problems occurring during the perinatal period, with the needs of families in this area requiring specific program responses. Children and adolescents also experience mental health issues and have needs that are different to adults. Overall, one in seven Australian children are likely to experience a mental illness, with high proportions of children living with anxiety and affective disorders. Mid to late adolescence is a common time for the onset of psychiatric disorders (Department of Health 2017).

It is critically important that mental health services are resourced and equipped to intervene as early as possible in order to minimise the impact that early experiences have on children during their developmental years and life course. It is also important to acknowledge that a significant number of children needing support will be living within a family unit that may have complex support needs themselves, requiring a more holistic and family-focussed approach. Services also need to recognise the role of young carers and work with them when caring for a parent with mental illness. Outcomes for these groups are described in detail in Chapter 4.

### Older people

Older Australians often experience complex combinations of physical illnesses as well as mental health problems. It is estimated that 10 to 15 per cent of older people experience depression, with 10 per cent also experiencing anxiety (Beyond Blue 2017). Men aged over 85 have a disproportionately higher death by suicide rate than other age groups (Department of Health 2017). Improving outcomes for older people in South Australia requires better integration of services, where both physical and mental health care can be provided. Services also need increased skills in recognising the risk factors for suicide in older people.

In the past, some of our older people have been harmed and placed at risk in state care facilities as a result of inadequate and unsafe care and treatment. DHW's response to the now closed Oakden Older Person's Mental Health Service outlines the work done to date and the path forward to implement the recommendations of the former Chief Psychiatrist's review into conditions at Oakden (Groves et al., 2017). The plan contains a range of initiatives for this group, described in Chapter 4.

### Culturally and linguistically diverse communities

There are many groups in the South Australian population who have diverse cultural needs and may be at higher risk of experiencing factors which impact on their mental health and access to and engagement with mental health services. This includes migrants, refugees, asylum seekers, and international students.

There are significant differences between migrants, refugees and asylum seekers; this includes taking account of both pre and post migration experiences.

There are many more people living in our community who have refugee experiences and have either arrived on other visa types such as family reunification, or who are still in the process of having their refugee protection claims assessed and/or finalised (STTARS 2018). These experiences, combined with communication barriers and fear or confusion on how to access and navigate services, place people at increased risk of not having their mental health needs adequately understood or met.

Prior to humanitarian settlement, the refugee experience is often marked by loss, trauma, violence and dislocation, with variable access to health care, nutrition, safety, and schooling in transit countries.

In terms of migrant groups, asylum seekers and refugees are most vulnerable to developing mental and physical illness. Asylum seekers and refugees experience elevated levels of mental disorders (Li, Liddell and Nickerson, 2016) in comparison with economic migrants.

These include higher risk of developing comorbid psychological disorders such as post-traumatic stress disorder (PTSD), anxiety, depression and psychosomatic disorders (Bhugra et al., 2011).

Equitable and timely access to mental health services is a significant issue for people from culturally and linguistically diverse backgrounds due to a range of fundamental issues, including:

1. The ability to respond to stresses of everyday living and adjusting to a new environment, which require them to rapidly learn new skills and create a safe environment for their family. Those stresses can be related to immigration status, prejudice, discrimination, loneliness, language barriers, lack of social ties and networks. In addition, navigating the health system, housing, school and employment, often compounded by ongoing concern for family that are missing or left behind. For asylum seekers there is the added mental health impact of imposed conditions of adversity, held or community detention, insecure residency, and restricted access to financial support, work and study.
2. The need to be part of the community and contributing members of society plays a significant role in developing a sense of belonging and wellbeing. Social isolation and associated language barriers can adversely affect people's confidence to function at ease within Australian society.
3. The need to address cultural issues associated with stigma and discrimination in order to promote help-seeking that is not crisis-driven. CALD people often have low health literacy that impacts on their understanding of mental health issues and access to appropriate services (Minas et al., 2013).
4. The need for services to provide culturally appropriate care that meets the diverse needs of CALD people. People might experience a low level of trust, fear of being judged by mainstream service providers, and fear of breaches of confidentiality and privacy, especially when an interpreter is needed.

All services will be commissioned to provide for the needs of CALD groups. Services to asylum seekers, refugees and other migrants who have experienced trauma will continue to be facilitated by an expert NGO providing both direct clinical and support services, as well as education and training to LHN and state funded NGO providers across the state.

A cultural peer based strategy for older CALD people is included in the outcomes section for the development of older persons services.

## People in regional and rural areas

A lack of timely access to appropriate services and support for people experiencing mental health issues in regional and rural communities has been identified as a key issue. People have voiced difficulties in having to travel great distances to access services or waiting for long periods for outreach services. Despite these experiences, it is important to acknowledge the creative and resourceful approaches to providing care that is occurring in many country areas, with many services working in partnership to best meet the needs of their local community.

All outcomes in the Plan are intended to apply across the state. Where there are not designated sub-specialist services in a regional area it is expected that clinical pathways will describe the response that consumers and carers receive, and uniform standards will be met.

## Veterans

The need to deliver prevention and early intervention services that improve mental health and wellbeing outcomes for veterans and active defence force personnel has been acknowledged in the development of the Plan. Recent government inquiries have emphasised the need to improve service responses to meet the mental health and wellbeing needs of both Australian Defence Force (ADF) personnel and veterans (SA Health 2016). The AIHW has reported that during 2014–2016, ex-serving men under 30 years of age experienced a suicide rate of 2.2 times that of Australians from the same age group (AIHW 2018). The Commonwealth Government has provided a further range of suicide prevention and mental health support services for serving and ex-serving ADF persons and their families (Australian Government 2013).

Some veterans may have complex or acute health care needs which require support from a range of providers and sectors. These needs may relate to mental illness, comorbid physical conditions, substance related concerns or other issues. Improving the level of service coordination and collaboration is essential for responding to veterans experiencing complex needs (Department of Veterans' Affairs, 2013).

Mental health services will continue to provide inpatient and outpatient services for Veterans and first responders (police, ambulance officers and paid and unpaid firefighters) who also are at risk of post-traumatic stress disorder.

The provision of outreach and sub-specialist support to other services will be encouraged as part of commissioning agreements. Future programs will employ peer workers, and peer therapists who have been trained in specific skills to provide evidence based treatment to fellow veterans and first responders.

Access to drug and alcohol services for people with comorbid mental illness and detoxification for people with a primary substance use disorder will be part of services on offer. Further consultation will occur with the Veteran's Community on establishing a sub-acute step down centre on the site of the Repat Health Precinct site. Funding for such an initiative is yet to be determined.

Whilst the Jamie Larcombe Centre is for the treatment of veterans with acute illnesses, the step down unit would enable veterans to prepare for discharge in a home like environment.

### Gender and sexually diverse people

People in Australia who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) have higher levels of mental health related distress and illness, with rates of psychological distress being up to twice as high as the general population. Major depressive episodes can be 4-6 times higher and suicide rates are higher than other groups in the national population. Significant work is required to reduce stigma and improve the appropriateness of mental health services for LGBTI communities (Department of Health 2017).

The LGBTI community have indicated that they often experience discrimination from mental health services, which can occur intentionally or unintentionally. Experiences include the lack of access to appropriate gender-neutral or other restroom facilities, and questions which are inappropriate or provide restricted options as part of mental health assessments or interventions. People can also experience staff responses which indicate a lack of understanding, as well as non-inclusive language.

The Plan will seek to address this by providing staff training in the delivery of safe and effective services to the LGBTI community. This includes the skills needed to counsel and support people considering or undergoing gender transition, and to work collaboratively with general health practitioners in this area.

With respect to the plan's principle of integrating services, opportunities to commission mental health services that are delivered with other primary health and non-government organisations will be developed during the life of the Plan. This will be further informed by the development of a specific clinical standards document, consultation with the LGBTI community about service priorities, and the outcomes of new initiative in other cities that may inform our planning such as the MIND Australia Equality Centre in Melbourne.

### People with sub-specialist mental health care needs

For people with complex mental health needs, access to services can be challenging and may result in people being referred to, and between, many different services before getting the right help. For example, people requiring specialist care for eating disorders or borderline personality disorder (BPD), having equitable access to integrated services has been described by people with lived experience as very difficult to navigate.

#### Eating disorders

Eating disorders are complex mental disorders that can have a range of significant physical impacts and are associated with high rates of comorbid mental health problems and mortality. Comorbidity includes anxiety and depressive disorders, personality disorders, substance misuse, and physical illness such as higher levels of cardiovascular disease and neurological symptoms (WHO 2017). People with eating disorders can experience stigma and discrimination when accessing services. Treatment responses need to be focused on both the eating disorder and the relevant mental and physical health comorbidities (Department of Health 2017).

Eating disorder services have been subject to review, with both adult and paediatric eating disorder services funded. Integration with primary health network and Medicare funded services can further expand the numbers of children and adults who receive evidence based therapies while receiving assessment and treatment from state operated tertiary services.

#### Borderline Personality Disorder

People diagnosed with borderline personality disorder (BPD) have among the highest levels of unmet need in our mental health system, and comprise up to 23% of outpatients and 43% of inpatients (NHMRC 2012). People living with this diagnosis experience high levels of emotional distress and difficulty in maintaining trust and stable relationships. Service providers need high-level skills and training to effectively engage consumers in treatment and care (Lawn & McMahon, 2015). 75% of people with a diagnosis of BPD experience comorbidity with other mental illness, including depression, anxiety and eating disorder. The most common comorbidities are depression and anxiety (Barrachina et al., 2011).

In South Australia, a specialist BPD Centre of Excellence is established. Its operation will be informed by the evidence of successful services elsewhere, for example, Victoria (Spectrum) and NSW (Project Air). The operation of the BPD Centre of Excellence will be assessed during the life of the plan, with its output and outcomes benchmarked with similar initiatives interstate. The expectation is that access to evidence based services and the quality of these services will improve across the state.

## Anxiety disorders

Current sub-specialist services for anxiety disorders will be supported under future commissioning with the expectation that services of existing recognised clinics are available for all people irrespective of location. The provision of sub-specialist tertiary services recognises the severity of the distress and disability associated with anxiety disorders, the need for practitioners to have both effective assessment and treatment skills including the use of specific therapies, and that by providing training and expertise these therapies can then be offered to people who have a range of conditions and co-morbid anxiety.

## Gambling

DHW will also expect a response to gambling disorders from our clinical services. Problem gambling leads to other mental illness, and gambling addiction is often missed in mental health clients (Victorian Responsible Gambling Foundation, 2017). Training and support for practitioners to implement clinical guidelines for the screening, assessment and treatment of gambling disorders will be provided. Clinicians with an existing interest in this area will be encouraged to provide sub-specialist support. As part of the coercion reduction strategy in this plan, it should be noted that people with serious mental illness and gambling disorders can be placed on Administration Orders under the *Guardianship and Administration Act 1993*. It is preferable where possible to identify and treat gambling disorders, and allow people to remain in control of their personal finances.

Models of service excellence will support practitioners and groups who wish to develop centres of excellence for people with specific needs, and link this to research and teaching. Mindful of the size of South Australia any such developments would in most instances need to provide state-wide access, be developed with consumer and community group support, and not duplicate existing groups. Work would need to support mental health services generally and have strategies to avoid fragmented care which can occur when services become sub-specialised.

## People in Corrections and Forensic Mental Health Services

People with mental health diagnoses are over represented within custodial settings, with 49% of prisoners reporting they have experienced a mental health condition, including substance use (AIHW, 2015). Aboriginal people are even more highly represented, constituting just over a quarter (27% or 7,982) of the total prison population despite comprising only 2.5% of the Australian population (Hudson, 2013a). Furthermore, Aboriginal youth account for approximately 50% of incarcerated children (AIHW 2017).

Forensic Mental Health Services provide limited psychiatric in-reach across South Australia's nine prison sites, and Child and Adolescent Mental Health Services provide in-reach into youth corrections.

Youth Corrections in-reach will be prioritised in the allocation of resources for youth mental health services. Young people with mental health issues in the youth justice setting require an integrated approach between mental health services and youth justice services to ensure their mental health needs are identified and addressed earlier in the illness cycle to minimise longer term impacts.

Over the course of the Plan in-reach services to Correctional facilities will expand. Given the small numbers of forensic mental health practitioners in South Australia it is anticipated that this expansion will use government services. However, if a market exists for non-government and for profit organisations, new services will be tendered for both within and outside government.

The need to expand forensic inpatient services from 50 to 80 beds is noted elsewhere in the Plan, with significant expenditure being required in this sector for a range of services. For this reason alternative funding through a Social Impact Bond will be considered. Within the short term DHW will work to develop a Bond proposal to fund an integrated service that delivers prison in-reach to women prisoners, and follow up on release. Such a proposal would provide necessary therapy, support and case management to a group of people who for the majority have experienced significant life trauma and are likely to respond to clinical input and psychosocial rehabilitation. Such an initiative would have financial savings by preventing future incarcerations and hospitalisations.

Plans to provide multidisciplinary prison in-reach will be developed in the short term, with an anticipated gradual deployment of in reach resources in the medium term.

## People experiencing homelessness and other social disadvantage

The stigmatisation and discrimination that people with mental health issues face can be further exacerbated by experiences of social disadvantage. This includes poor access to economic, social and cultural rights, work and education, and access to necessary services. Homelessness and inappropriate incarceration are far more common for people with mental disorders than for the general population, exacerbating a person's marginalisation and vulnerability in the community (WHO, 2013). An integrated approach to service delivery across the mental health, health and social services sectors is critical in ensuring that people experiencing social disadvantage have timely and appropriate access to services that address their needs.

Services commissioned under the Plan will be expected to interface with homelessness networks and housing providers. New youth staff will be expected to integrate with youth homeless services and join youth workers to see homeless young people wherever they are for the purpose of assessment and treatment.

The practice of embedding adult mental health workers in a homelessness team will be supported and encouraged in future commissioning arrangements.

Integrated service delivery with housing providers will be supported by memorandums and other agreements, to enable clients of DHW funded services to access community housing stock, while receiving support.

During the life of the Plan, DHW will continue to commission services that integrate emergency shelter, case coordination and mental health care. However, in instances where consumers are NDIS eligible it would be expected that this funding be sought, so that DHW funds are used to support non-eligible consumers.

### People with comorbid disability

Approximately 6,800 people in South Australia experience an intellectual disability, with reports of up to 40% of people with intellectual disability experiencing co-occurring mental health conditions (Department for Communities and Social Inclusion 2013). Similarly, higher rates of mental health co-morbidity exist for people who have experienced head injury or neurological disease. Mental health services need to be accessible for people with autism spectrum disorders who have other co-morbid mental illnesses or need support managing behaviour and distress.

Services also need to be accessible for people with complex communication needs due to sensory, physical and cognitive impairments.

The three pillars of the Plan – personalisation, integration and safety and quality will be applied to mental health service provision working with consumers and their carers, other health providers, and disability support providers.

People with a disability will be able to access local mental health services that in turn will be supported by a sub-specialist disability mental health service. This service will be commissioned using existing resources to provide supervision, advice and, where required, sub-specialist assessment and co-management by a sub-specialist clinician. This service will also offer rotating training placements to upskill the broader workforce, as well as contribute to training and education programs in this area.

Services are currently provided by a small Centre for Disability Health at Modbury. Services commissioned under the Plan will be integrated with the work of this Centre.

### Children and Adults with Attention Deficit Hyperactivity Disorder

Attention Deficit Disorders will be a designated area of sub-specialist expertise with commissioned services encouraged to develop diagnostic and treatment expertise in this area. For all age groups' accurate diagnosis, assessment and treatment of mental health co-morbidities, and where possible, the use of psychosocial and behavioural interventions to minimise the use of stimulants where possible will be relevant themes. New Child and Adolescent staff embedded in education settings will be encouraged to gain expertise in this area of practice. Specialist child psychiatry clinics will offer opinions and second opinions for paediatricians.

Specific quality improvement and training funds will be designated to assist clinicians with developing skills in assessment and interventions for adults with ADHD. Quality improvement will also focus on supporting better integration with primary health network funded mental health services and private practitioners, enabling consumers to be triaged and provided with the most appropriate care in a timely manner. A standard for assessment and treatment of ADHD will be developed.



### 3.7 Key contributions from people with lived experience and those who support them

Given their unique perspectives, people with a lived experience of mental health issues, and their families and carers, have a critical role in advising and advocating on how services can best operate. This includes exploring practical ways to promote recovery and to support a holistic response across a range of sectors including education, employment, housing and family support.

The demand for recognition of the role of people with lived experience arose at the same time when other socially excluded groups, including people with disabilities and other population groups, questioned their treatment. Across the board, there has been a demand for the right to advocate for changes in the way society has viewed and treated people with mental health problems. Lived experience involvement is now universally recognised as a pivotal mechanism for social enfranchisement and for ensuring human rights practice in mental health services.

Participation and co-design by consumers and carers with lived experience has increasingly been integrated within mental health services policy, planning, service design and delivery in South Australia. The Plan has embedded this approach, recognising that this is absolutely essential for achieving high quality mental health services for one of the most vulnerable groups in society.

#### Lived experience community feedback on mental health services

While there have been several past consultations involving people with lived experience, specific attention was given to the question of what is needed to improve mental health services in South Australia? Consultation feedback is summarised here.

- > Mental health services need to address the needs of the community that is beyond their immediate mental health needs.
- > Current avenues for receiving treatment in a timely fashion are inadequate.
- > There is a need for better ways to access information.
- > There is a continuing use of threats to get people to comply with treatment – this is coercive and fails to take into account a person's thoughts and feelings.

- > While advocacy mechanisms and bodies exist such as the Community Visitor Scheme, the Office of the Public Advocate, the Disability Advocacy and Complaints Service of SA Inc., the Advocacy for Disability Access and Inclusion (ADAI) and the Disability Rights Advocacy Service Inc., there is limited use of these services to facilitate access to individual advocacy to enable a person to exercise their rights in accordance with the Convention on the Rights of Persons with Disabilities (United Nations 2006) and the WHO Mental Health Action Plan 2013-2020 (WHO 2013).
- > A system is needed that is focussed on early intervention rather than acute responses.
- > Better monitoring of medications and their side effects including their impact on physical and oral health is needed.
- > The mental health system does not facilitate access for people when they are experiencing a mental health crisis. For example, the triage service has limited capacity to support access to community mental health services or referral to GP services. Similarly, GP services have limited capacity to refer into a community mental health service.
- > Service options in private health care i.e. psychiatry, psychology are limited due to long waiting lists or high costs even with the availability of the Better Mental Health Access Program.
- > The current emphasis is on the medical model of diagnosis and treatment and should be rebalanced towards a broader social response framed by compassion and support to promote recovery.
- > More options need to be available as alternatives to current telephone support services such as Lifeline, Beyond Blue and the Lived Experience Telephone Service (LETS) Peer Support Line, and particularly, greater coordination is required between DHW's mental health triage services.
- > For want of other options, people experiencing a mental health crisis are funnelled into emergency departments. Alternatives to emergency departments such as 'Safe Haven Cafe' and 'Step-in (walk-in)' services are needed for first response services.
- > Advocates should be available in emergency departments to support people and reduce the impact or trauma.
- > Mental health services should have welcoming, caring, homelike environments that encourage connection and purpose in life.



> Supporting recovery has to be a key focus for mental health services and this requires a greater emphasis on:

- recognition of the important role played by peer workers in supporting recovery and the greater availability of these workers to walk and work alongside consumers during their recovery
- services working with a consumer's protective factors to support their recovery
- a wide range of services to be available beyond medical diagnosis and treatment to include social and other supports such as other therapeutic modalities, education, housing, life skills, employment and training
- all services embed a trauma informed approach
- all services place emphasis on human rights and voluntary participation in care
- all services place emphasis on the role of peer workers as integral to the mental health workforce
- all services ensure consistency of referral information and processes
- mental health services build relationships with all carers to ensure their inclusion taking account of any additional support carers may need
- mental health services appropriately support carers through information sharing and active involvement in treatment and care.

### 3.8 Key principles of personalised therapeutic care

The crucial need to provide the best treatment and therapeutic engagement is well recognised across the mental health system. However, according to feedback, this continues to be an area of disconnection and adverse experience. Achieving consistency and ensuring safe, effective standards of care must be an explicit and observable process across all disciplines. There must be real engagement and commitment by services responsible for treatment outcomes to ensure that they are person-centred and based on 'feedback informed' practices.

Personalised care embraces a feeling of being respected, welcomed and engaged in assessment and treatment options, as well as the way specific therapeutic interventions are developed. It is also about creating space for consumer empowerment and choice, ensuring that consumers are central to discussions regarding treatment and collaborative care planning.

It has only been in recent times that attention has been given to whether the person seeking help feels that the approach or intervention they are offered is beneficial. The personal experience and effect of treatment has tended to remain exclusively within the domain of the clinician. It is now time for mental health systems to broaden ways of measuring an individual's response to therapy and treatment, using more individual-based markers or indicators of consumer response.

#### Trauma informed approach

Trauma is over represented in mental health population groups, particularly for those who access treatment services. Trauma can be described as resulting from 'an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotion, or spiritual well-being' (SAMHSA 2014a).

A trauma-informed approach is based on the fundamental principles of trauma awareness, aiming to prevent re-traumatisation by including consumers and staff in decision making and promoting conditions of safety and trust, choice and collaboration (Procter et al., 2017). Consideration of symptoms and behaviour through a trauma-informed lens means (for example) that consumer responses that might have otherwise been considered as aggressive, deliberately difficult or uncooperative behaviours, would instead be interpreted as coping strategies the person has developed in the context of managing traumatic experiences (Procter et al., 2017).

The link between trauma and the development of mental health conditions is clear and the experience of trauma can adversely impact a person's engagement with services, responses to treatment and personal recovery (NSW Ministry of Health 2018).

Experiencing a traumatic event can impact on many aspects of a person's life including relationships, family, social and working life. Many people will recover quickly with support from friends and family. However, if the emotional impacts are more intense and persistent, they may lead to mental health issues such as depression, anxiety, post-traumatic stress disorder (PTSD), substance use, or exacerbate existing mental health conditions (NSW Ministry of Health 2018).

Part of the challenge of responding to trauma is maintaining personalised approaches and helping individuals and groups at increased risk of trauma exposure. People who are often first on the scene to traumatic incidents such as police, ambulance and fire services can be exposed to a range of significant trauma situations that can impact on their mental health and wellbeing. Serving and ex-serving ADF personnel can also have an increased exposure to trauma related events which may lead to PTSD, social and emotional distress and increased suicidal thinking and behaviour (AIHW 2018). The need to invest in early intervention and prevention strategies to improve health outcomes for these groups has been considered in the development of the Plan.

Trauma Informed Care and Practice (TICP) has been recognised as an integral part of a recovery based approach. Studies have demonstrated that training on TICP leads to enhanced therapeutic relationships and encounters and can lead to reductions in seclusion and restraint practices in mental health services (Ashcraft & Anthony 2008; Sweeney et al., 2018). In circumstances where traumatic experiences, including where more restrictive practices are necessary, it is critical that debriefing for the person, staff and others who may be indirectly affected by the event is facilitated.

It is also important to recognise the need to build systems and cultures that support and promote trauma informed care and practice. Strong leadership is required to drive trauma informed care within, across and as part of overall organisational function. In addition to the above principles, Substance Abuse and Mental Health Services Administration (SAMHSA) have developed the following 10 domains that aim to increase broader and organisational governance and leadership:

- > governance and leadership
- > policy
- > physical environment

- > engagement and involvement
- > cross sector collaboration
- > screening, assessment and treatment services
- > training and workforce development
- > progress monitoring and quality assurance
- > financing
- > evaluation (SAMHSA 2014).

### What people told us

As part of the development of the Plan, an open forum held in November 2018 invited participants to consider the following question: *How can mental health workers better demonstrate working from a trauma informed approach?* Key themes of feedback included:

- > trauma support needs to be provided and addressed in line with the person's own personal experiences, recognising and respecting their own perspective at that point in time
- > involvement of family and friends
- > looking at the way people are trained in trauma informed care, ensuring that peer workers are trained too
- > ensure that training focuses on how the knowledge and skills can be applied in practice within the different settings
- > ensuring peer workers are embedded into services where people might present in distress, aiming to provide a more therapeutic environment and minimise further trauma
- > acknowledging that telling and re-telling stories can be traumatising in itself and providing safe spaces can facilitate assessments and interventions in a more trauma informed way
- > treatments and services that take into account the 'human experience'.

### 3.9 Key attributes of integrated models of service delivery

Integrated models of service delivery occur when services work together in partnership to provide a coordinated response to meet individual needs. To work together effectively, services must build on a foundation of:

- > shared and agreed values
- > clearly defined and communicated roles and responsibilities
- > mutual respect and openness to different perspectives, experience and expertise
- > formal and informal agreements that clearly state the terms for shared governance, funding and risk
- > strategic planning that takes a holistic view of the bigger picture, to identify and reduce gaps and duplication
- > shared information and open communication
- > joint care planning that considers all partners in care as equals, including people with lived experience, their families and carers
- > proactive management and planning of anticipated transition points (i.e. child to adult) and known events (i.e. discharge).

### 3.10 Key attributes of an outcomes driven workforce

An outcomes driven workforce is supported by a compassionate culture with bold and resilient leadership. It promotes person-centred values and delivers person-centred interventions that have therapeutic benefit to the consumer at every contact. It is planned and designed around population needs, forecasts of workforce demand and contemporary models of care. An outcomes driven workforce is also:

- > capable and able to do the job because the right people with the right skills and values have been recruited, with systems in place to support people to use those skills
- > has the capacity to meet service demand
- > employs different types of innovative roles for new ways of working
- > provides an environment for staff which enables them to be the best they can be, to grow and excel
- > builds and supports resilient individuals and teams
- > enables people to learn and develop and continuously improve their practice
- > has processes in place to evaluate and identify what is working well, and innovative ways for making improvements for staff and consumers
- > supports people to take care of themselves and maintain good mental health and wellbeing.

# 4. Data and Modelling

## 4.1 Service Data

In this section we consider how South Australia currently performs, how resources are currently allocated, and how future resource allocations might occur under the Plan based on the National Mental Health Services Planning Framework (the Framework).

The Framework was developed by the Commonwealth Government in conjunction with states and territories as an action arising from the Fourth National Mental Health Plan. It provides a tool to assist governments with planning their mental health system and resourcing mental health services to meet the needs of the population (the National Mental Health Services Planning Framework Team 2017).

The NMHSPF contains a number of key assumptions:

- > nationally consistent - an 'Australian average' estimate of need, demand and resources;
- > flexible and portable - to suit jurisdictional priorities and other variations in a user friendly format;
- > not all, but many - will not account for every circumstance or service possibly required;
- > not who, but what - will capture the types of care required, but will not define who is to deliver; and
- > evidence and expertise - identify what services 'should be' provided and underpinned by evidence.

The Plan has used the Framework to guide thinking regarding the resource impacts of proposed outcome changes. It has been developed to guide evidence-based mixed level of services and workforce to meet local service requirements. The Framework can be used for regional planning and resource allocation to support regional needs assessment, meeting identified service gaps and for targeting resources.

In this context, it should also be noted that the Framework is under review, and will be reapplied during the life of the Plan. The Framework has been used to set priorities for the state rather than master plan in a prescriptive way. In addition, the Plan proposes the addition of Crisis Retreat Residential Centres to the service mix. These centres provide acute crisis care based on a recovery model, with highly skilled professional staff and peer workers in high quality therapeutic but safely designed settings. This is the latest iteration of community alternatives to hospital stays that began with the Trieste model in Italy, and has been adapted in various cities around the world. These beds are not a part of the Australian Framework.

### How do we compare nationally?

The Australian Institute of Health and Welfare publishes annual statistical information for a range of mental health resources, activity and performance in its online publication – *Mental health services in Australia* ([aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary](http://aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary)).

#### In summary, South Australia, compared to the National average:

- > spends above or near the national average for most service categories, except youth and a slightly lower expenditure per capita for child and adolescent services;
- > slightly less than the national average use for Medicare services and above the average for items sourced from the Pharmaceuticals Benefit Scheme;
- > provides services to more new clients;
- > utilises emergency departments at a greater rate, admits more patients to an inpatient setting and has longer waiting times in emergency departments;
- > has a shorter length of stay in all inpatient service categories;
- > incurs higher daily costs for inpatient services across all categories;
- > sees more community consumers than any other state;
- > has more staff per 100,000 of population;
- > has more overall inpatient and residential beds per 100,000 of population, but has less beds in specific categories such as child and adolescent services and general non-acute services;
- > has more supported accommodation places than the national average; and
- > has a higher seclusion rate than the national average.

## The Department for Health and Wellbeing Mental Health Performance Snapshot

The Australian Institute of Health and Welfare (2018) provides an overview of how South Australia's clinical mental health services compares to the national average across a number of performance measures:

### Emergency Department

South Australia has:

- > The highest rate of mental health related presentations to emergency departments in Australia – 4.8% versus the national average of 3.6%
- > The highest rate of mental health presentations to emergency department for the top three triage categories – resuscitation, emergency and urgent
- > The highest rate of all consumers presenting to an emergency department by ambulance - 52.5% compared to the national average of 44.8%. In South Australia there is a greater role for ambulance rather than police for mental health transport.
- > An admission rate of 45% to an inpatient unit (local and other unit) from an emergency department compared to the national average of 39%.

## Community Mental Health

- > For general adult service category – the number of days in community treatment were higher (79.2%) than the national average (68.7%). A treatment day refers to any day on which one or more community contacts (direct or indirect) are recorded for a registered consumer during an ambulatory care episode. For instance in South Australia, 79.2% of all community treatment days were from the general adult group and yet this group is 63.1% of the population.
- > For child and adolescents, youth, older persons and forensics – community treatment days were lower in South Australia compared to the National average

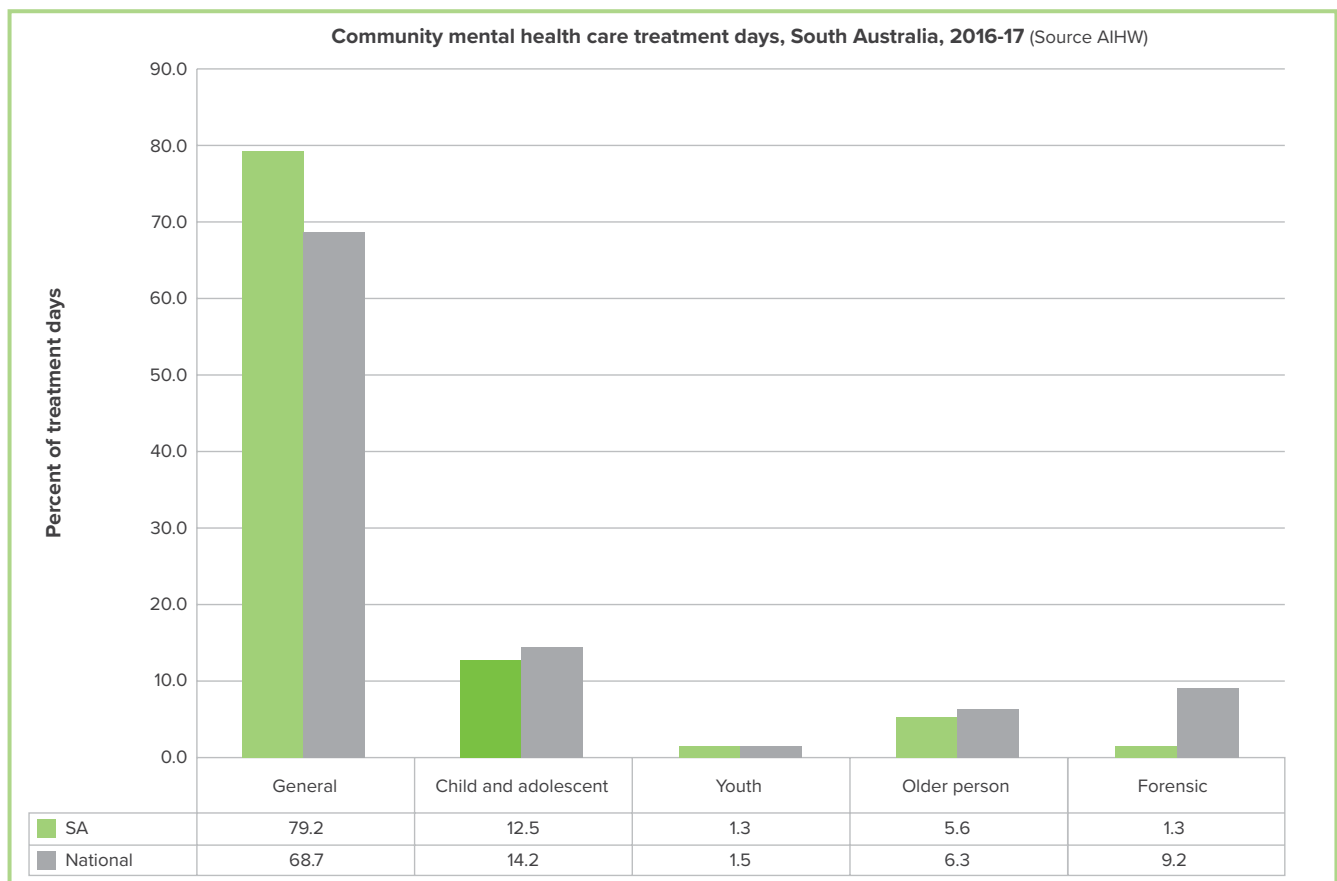


Figure 2: Community Mental Health Care Treatment Days – 2016-17

## Community Mental Health Workforce

The core business of modern mental health services is to support people to recover and remain well in the community and to prevent unnecessary hospitalisation. The clinical care needed for this is provided by community mental health teams.

### How do we compare nationally?

The latest South Australia comparisons of Mental health services in Australia AIHW data for 2016-17 shows South Australia is above the national average for FTE per 100,000 of population. The table below shows that South Australia currently has approximately 24% more community mental health staff per 100,000 of population than the national average.

Note that both staffing for youth and older persons is less than the national average.

Table 1: Community FTE per 100,000 – SA vs National

Indicator	SA	National
Community – General per 100,000 population	66.9	50.1
Community – Child & Adolescent per 100,000 population	47.8	36.9
Community – Youth Persons per 100,000 population	4.1	7.5
Community – Older Persons per 100,000 population	19.7	22.4
Community – Forensic per 100,000 population	1.6	1.7
<b>Community – Total per 100,000 population</b>	<b>56.1</b>	<b>45.1</b>

## National Mental Health Services Planning Framework – Community Services

Note: This does not include forensic mental health staff as they are not part of the current Framework model. Figures also exclude administration staff.

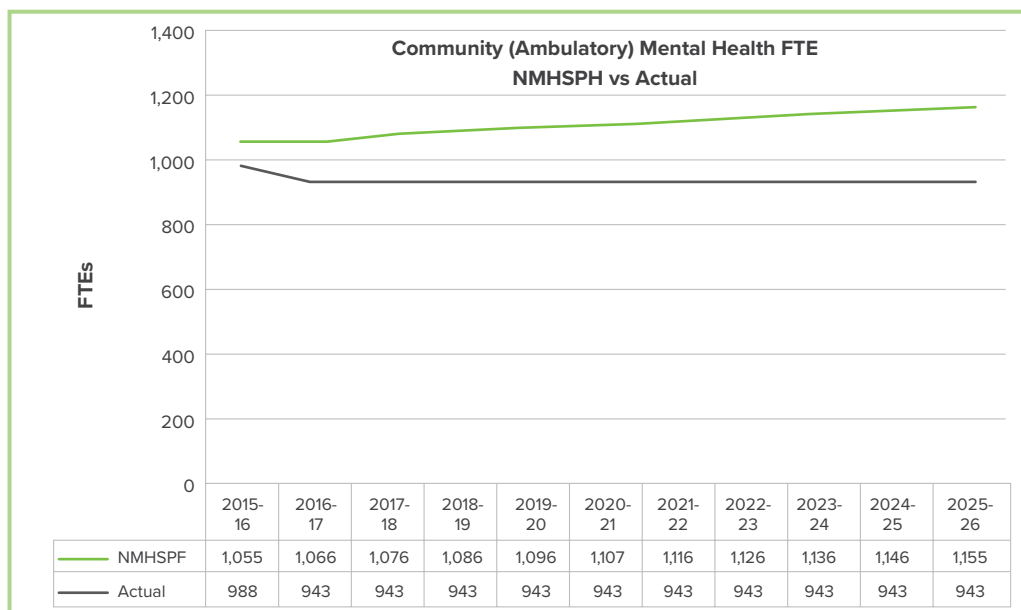


Figure 3: Community (Ambulatory) Mental Health FTE Framework vs Actual



The Framework also estimates community mental health staff for the various age categories will grow by 50 FTE from 2018-19 to 2023-24. The growth is described in the table below, with the largest being in services for the +65 years age group which is reflective of the ageing population.

There will be resource challenges in aligning the community mental health workforce between what is actually in place using the most recently published data (from 2016-17) in the following table compared against the outcomes estimated by the Framework by 2023-24. The table also summarises the position that indicates a need for a further 193 FTEs across the age groups. The Framework estimates that an additional 81 FTEs and 152 FTEs are required in the child and adolescents and older persons age groups respectively.

Table 2: The Framework and Actual FTE by Service Category

NMHSPF and Actual FTE by Service Category				
	Current	Framework Modelled 2018-19	Framework Modelled 2023-24	Variance between actual now and modelled in 23-34
Child and Adolescents (0-17 years)	176	245	257	81
General Adults (18-64 years)	706	655	665	-41
Older Persons (+65 years)	61	188	213	152
All ages	943	1,086	1,136	193

\*Last published AIHW in March 2019 was for 2016-17 data. Youth apportioned between child and adolescents and adults. All numbers have been rounded.

No state at this time has achieved the modelling outcomes which are reflected in the national comparison figures. There is also a risk that the framework categories are traditional (based on the reviews of evidence where it exists and otherwise by consensus of all the expert clinical and other staff assembled nationally in 2011-13 and then again in 2016 and once again occurring now) and the best new initiatives to fund may not be determined by allocations in the modelling, particularly if there is an overlap between categories.

Once again it should be noted that this framework data does not include forensic mental health services. Staffing for prison in-reach services, Court liaison and community forensic mental health is required which is additional to these numbers.

The Framework will not be used as the basis of a “master plan” for the next 5 years. Progress against the Framework will be continually reassessed during the life of the Plan and formally reported at 18 months, 3 years and 5 years, against the latest version of the Framework that is in place at that time as well as comparisons across Australian jurisdictions. It is expected that later versions of the Framework will account for the role of the NDIS, and include modelling for forensic mental health services.

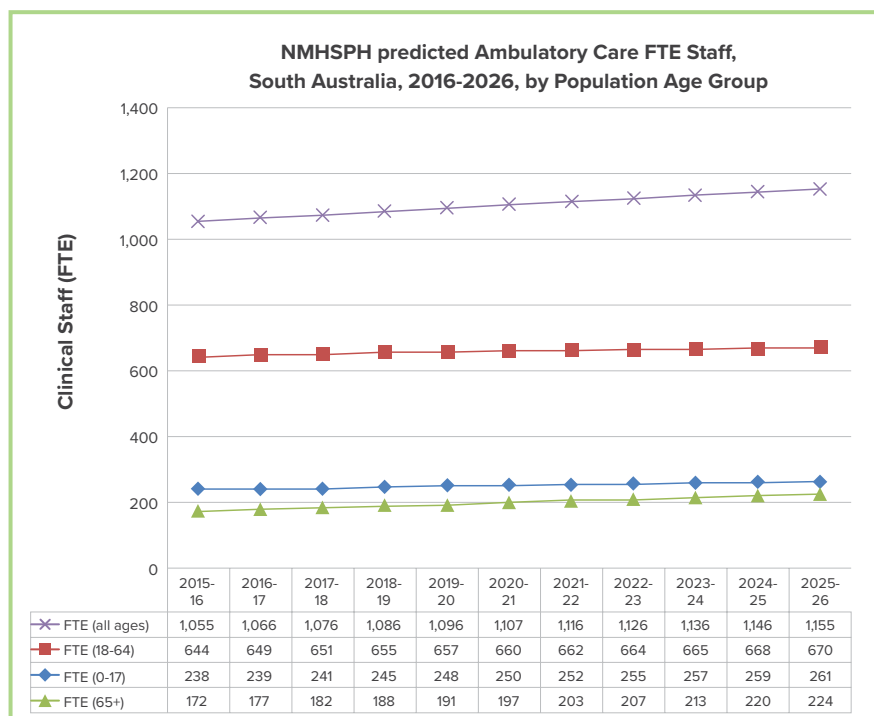


Figure 4: The Framework predicted Ambulatory Care FTE Staff, South Australia 2016-2026

The NMHSPF predicts that the needs for ambulatory care staff in South Australia will increase by about 10%, or 100 FTE, over the ten years from 2015-16 to 2025-26. This is simply due to projected population increase of about 0.9% per year over that period.

## Implications for the Plan

The assessment of the Framework against the SA current landscape, supported by expert and local consensus opinion has identified priority areas for future expansion of community mental health services:

- > Child and adolescent mental health services
- > Older persons mental health services

As new resources become available for community staffing they will be preferentially applied in those areas.

Based on the interstate comparisons and recent inspections of youth services, it is reasonable to conclude that youth services should represent another priority area.

Rigid overlaps between services will be avoided with the following new arrangements:

*Table 3: SA Public Mental Health Services – Proposed Age Ranges*

Child and Adolescent Services	0 – 18 years	New referrals routinely to age 16, but can be accepted up to age 18 when CAMHS is the most appropriate service.  Adolescents can stay with the service until age 19 or in some cases beyond if in their interests to do so.
Youth Mental Health Services	16 – 24 years	New referrals for this age group will predominantly go to the Youth Team, unless it is in the interests of the young person to attend a subspecialist adult program.
Adult Mental Health Services	18 – 70	Can accept referrals for people aged 18 – 24 via Youth Mental Health Services intake.  Receives all referrals for people aged 24 – 70.  People aged 60 – 70 with dementia may be referred to the older persons service, while people with mental illness will be managed by adult services.
Older Persons Mental Health Services	70 onwards	Routinely accepts all referrals over age 70.  Can accept referrals for consumers aged 60 – 70 with dementia or who are physically frail

The Framework assumes that adult service clinicians spend more face to face time with clients than is currently the case in South Australia and other jurisdictions. Efforts will be made to increase the efficiency of adult services through reducing current time-consuming paperwork requirements, and through the provision of mobile technology to access information and make notes when providing home treatment.

The Plan will be informed by the community staffing modelling from the Framework in two ways. First, the modelling will be used to set priorities in the expansion of services, but the plan does not commit the State to achieving the Framework benchmarks. The State would incrementally work towards the Framework, seeking at the same time to maintain an above average investment in mental health staffing as compared by AIHW to other states.

Traditional age ranges will be readjusted with overlap based on the clinical and developmental needs of consumers. Youth services will be the key service for 16 to 24 year olds and supported to do this through both new resource allocations, and an expectation that internal resource allocations within LHNs will address inequities between age groups. An “overlap period” will enable people aged 65 to 70 to receive services from adult services, with options for some groups to get services from older persons services.

Given that there are a number of new adult based initiatives in this Plan such as Urgent Mental Health Care Centres and increased drug and alcohol workers in mental health settings, the numbers of adult staff will initially increase, but with the intention during the life of the plan of maintaining rather than increasing adult mental health relative to child and adolescent and older person’s mental health. Adult services will increasingly support other professionals in integrated models rather than be expected to provide all services to clients.

## Bed based services

The latest AIHW reporting is from 2016-17 and illustrates South Australia’s position relative to the national average, demonstrating at that time acute beds were slightly above the national average, while the number of child and adolescent beds was less.

Table 3: Mental Health Beds – Rate per 1000,000 population – South Australia vs National

Indicator	SA 16/17	National	SA Mar 19
Source of Data	AIHW	AIHW	Internal
<b>Beds per 100,000 by Target Setting – Public</b>			
Inpatient – General Acute per 100,000 population	27.8	24.5	*27.7
Inpatient – General Non Acute per 100,000 population	3.8	9.5	3.8
<b>Inpatient – General Total per 100,000 population</b>	<b>31.6</b>	<b>34.0</b>	<b>*31.9</b>
Inpatient – Child & Adolescent Acute per 100,000 population	3.3	4.6	3.2
Inpatient – Child & Adolescent Non Acute per 100,000 population	0.0	0.5	0.0
<b>Inpatient – Child &amp; Adolescent Total per 100,000 population</b>	<b>3.3</b>	<b>5.1</b>	<b>3.2</b>
Inpatient – Youth Acute per 100,000 population	0.0	1.7	0.0
Inpatient – Youth Non Acute per 100,000 population	0.0	0.0	0.0
<b>Inpatient – Youth Total per 100,000 population</b>	<b>0.0</b>	<b>1.7</b>	<b>0.0</b>
Inpatient – Older Persons Acute per 100,000 population	22.8	19.4	20.3
Inpatient – Older Persons Non Acute per 100,000 population	21.5	8.0	0.0
<b>Inpatient – Older Persons Total per 100,000 population</b>	<b>44.3</b>	<b>27.4</b>	<b>20.3</b>
Inpatient – Forensic Acute per 100,000 population	0.6	1.6	0.6
Inpatient – Forensic Non Acute per 100,000 population	3.1	1.9	3.8
<b>Inpatient – Forensic Total per 100,000 population</b>	<b>3.7</b>	<b>3.5</b>	<b>4.4</b>
Inpatient – Total Acute per 100,000 population	22.1	20.7	* 21.6
Inpatient – Total Non Acute per 100,000 population	8.6	8.7	4.1
<b>Inpatient – Total Acute + Non-Acute per 100,000 population</b>	<b>30.7</b>	<b>29.4</b>	<b>*25.7</b>
Inpatient – Total Residential per 100,000 population (24 – Hours)	7.0	6.9	7.9
<b>Inpatient – Total Acute + Non-Acute + Residential per 100,000 population</b>	<b>37.7</b>	<b>36.3</b>	<b>*33.6</b>
Residential –Government 24 Hour per 100,000 population	5.8	5.7	6.7
Residential –Government non 24 hour per 100,000 population	0.6	0.0	0.6
<b>Residential –Government Total per 100,000 population</b>	<b>6.4</b>	<b>5.7</b>	<b>7.3</b>
Residential – NGO 24 hour per 100,000 population	1.2	1.2	1.2
Residential –NGO non 24 hour per 100,000 population	1.4	2.4	1.4
Residential –NGO Total per 100,000 population	2.6	3.6	2.6
<b>Residential – Total per 100,000 population</b>	<b>9.0</b>	<b>9.4</b>	<b>9.0</b>
<b>TOTAL – Private Beds per 100,000 population</b>	<b>n/a</b>	<b>12.3</b>	<b>5.2</b>
<b>TOTAL – BEDS per 100,000 pop. (Public+Private)</b>	<b>n/a</b>	<b>41.7</b>	<b>30.9</b>
<b>TOTAL – BEDS per 100,000 pop. (Public+Private+Residential)</b>	<b>n/a</b>	<b>48.6</b>	<b>38.8</b>

\*Note these figures include beds for veterans.

It should be noted that in many other jurisdictions veterans use private sector beds rather than a public sector unit such as the Jamie Larcombe Centre. This needs to be considered when making comparisons, so when externally funded Veterans beds are not counted, the general acute beds drops from 27.7 to 25.9 per 100,000 (March 2019 figures).

- > Inpatient – General Acute per 100,000 pop. – Less 20 Allocated Veteran’s Beds = 25.9.
- > Inpatient – General Total per 100,000 pop – Less 20 Allocated Veteran’s Beds = 29.7
- > Inpatient – Total Acute per 100,000 pop. – Less 20 Allocated Veteran’s Beds = 20.2
- > Inpatient – Total Acute + Non Acute per 100,000 pop. – Less 20 Allocated Veterans Beds = 23.9
- > Inpatient – Total per 100,000 pop. (Acute+Non-Acute+24 Residential) – Less 20 Allocated Veterans Beds = 31.

In addition, it should be noted that South Australia bed numbers per 100,000 of population will decrease for the next national reporting period due to the closure of 64 non acute older persons beds at Oakden and the opening of 16 older persons residential beds at Northgate. There will also be an additional 10 forensic beds in the next reporting period for South Australia.

When interpreting performance against national averages, whether this is for community staffing or beds, the necessary caveat is that jurisdictions around Australia have difficulty meeting population demand. This is where the Framework needs to be considered. These comparisons do not demonstrate imbalances in investment in different components of the system.

### Current State of Mental Health Beds

Mental Health beds in South Australia have grown modestly overall over the past five years. However there have been some significant changes across service types including:

- > an increase in acute beds
- > an increase in residential beds
- > an increase in Forensic beds
- > a decrease in non-acute older persons beds (associated with the closure of the Oakden facility).

Table 4: Mental Health Beds

Bed Changes by Services Category					
Beds	2014-15	2015-16	2016-17	2017-18	2018-19
Acute Beds (incl Forensic)	353	374	375	374	377
Non-Acute Beds	104	104	104	40	50
Intermediate Care Beds	45	30	30	30	30
Residential Beds (incl Forensic)	80	100	100	116	116
Non-Acute Forensic Beds	32	42	42	42	42
<b>TOTAL</b>	<b>614</b>	<b>650</b>	<b>651</b>	<b>602</b>	<b>615</b>

Bed Changes by Age or Services Category					
Beds	2014-15	2015-16	2016-17	2017-18	2018-19
General Adults	428	444	449	448	451
Child & Adolescent Acute	12	12	12	12	12
Older Persons	134	134	130	82	82
Forensics	40	60	60	60	70
<b>TOTAL</b>	<b>614</b>	<b>650</b>	<b>651</b>	<b>602</b>	<b>615</b>

Note – Acute beds include 24 beds for Veterans located at the Jamie Larcombe Centre.

### Description re: bed types

**Acute:** acute psychiatric hospital beds at general hospitals (metropolitan and country) and at Glenside Hospital. This number includes 37 psychiatric intensive care beds for adults and 24 closed beds for older people.

**Non-acute:** inpatient rehabilitation beds at Glenside Hospital, and long term aged care beds.

**Sub-acute beds:** Includes Intermediate Care Beds, and Residential Rehabilitation Beds

**Intermediate Care Centre (ICC) Beds:** non-hospital beds providing voluntary admission to acutely unwell people, as an alternative to hospital care and “step down” for consumers in hospital who no longer need an acute hospital bed, but are not well enough to return home with community support.

With new Acute Crisis Retreat Beds (see below) taking on some of the roles of the Intermediate Care Centre, in the new plan these beds will be refashioned. One of the existing centres will become a Youth centre, and the other a metropolitan centre, and country programs will have an ongoing sub-acute role.

**Residential Rehabilitation Beds:** Beds at Community Rehabilitation Centre providing focussed rehabilitation for people who need intensive rehabilitation and support that cannot be delivered in community accommodation.

**Forensic Beds:** This figure includes acute beds (8), rehabilitation beds (42), step down beds (10) and sub acute rehabilitation beds (10).

During the life of the plan a new category will be added:

**Acute Crisis Retreat Beds** (as described later in the Plan): a community unit operated by a LHN, NGO or private sector provider that delivers crisis residential care along with clinical assessment and treatment. These units are designed to create a therapeutic welcoming setting in a safe environment that has line of sight and design features of inpatient units and can accept involuntary consumers. It is expected that these units will accept people with higher acuity than ICCs, have higher staffing levels, and care for people who would otherwise be admitted to an acute unit. American units have high staffing levels to deliver intensive interventions – including roles for medical staff, nurse practitioners, allied health and at least 20% peer worker staffing. The units are planned to deliver a recovery based model, uphold rights and apply zero suicide safety models.

The development of a Crisis Retreat model for South Australia is part of the Plan, with the expectation that the first centre is operating in the medium term.

**Acute Behavioural Assessment Unit Beds:** The ABAU is a collaborative model between Emergency Department Toxicology physicians, Mental Health and Drug and Alcohol services that fast tracks the assessment and management of behaviourally disturbed consumers. Units care for behaviourally disturbed consumers of any aetiology, including people with acute and chronic substance abuse; people in psychosocial crisis; people with acute psychiatric conditions; and people recovering from acute toxidromes secondary to a drug overdose not at risk of requiring intubation (Braitberg 2018).

### National Mental Health Services Planning Framework – Inpatient and Residential Services

The Framework contains a number of bed-based mental health care services for population categories such as general adults, child and adolescents and older persons, but excluding forensics. They are:

- > acute inpatient services (hospital based)
- > sub-acute services (residential and hospital or nursing home based)
- > non-acute extended treatment services (residential and hospital or nursing home based).

Table 5 provides a summary of bed numbers derived from the Framework compared to current bed numbers in South Australia to 2023-24. The table includes beds operated in the private sector. Public sector planning is based on minimal private sector change and would need to accommodate changes in private provision if they occur.

Apart from some private sector re-location of beds within the metropolitan sector there have been no other plans lodged with DHW for the private mental health sector at this time.

Table 5: NMHSPF – Mental Health Bed Profile Summary

NMHSPF – Mental Health Bed Profile Summary Based on Extending Current Stats vs Framework Modelling						
PUBLIC – ACTUAL	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Acute	369	372	372	372	372	372
Sub-Acute	30	48	48	60	60	60
Non-Acute	146	146	146	146	146	146
<b>TOTAL PUBLIC – ACTUAL</b>	<b>545</b>	<b>566</b>	<b>566</b>	<b>578</b>	<b>578</b>	<b>578</b>
PUBLIC – NATIONAL MODEL	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Acute	282	284	287	290	292	294
Sub-Acute	130	131	133	134	137	140
Non-Acute	361	366	370	376	380	386
<b>TOTAL PUBLIC – NATIONAL MODEL</b>	<b>773</b>	<b>781</b>	<b>790</b>	<b>800</b>	<b>809</b>	<b>820</b>
NET SHORTFALL – PUBLIC	228	215	224	222	231	242
PRIVATE	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Total Private – Actual	91	91	92	93	93	94
Total Private – Model	92	92	92	92	92	92
<b>NET SHORTFALL – PRIVATE</b>	<b>-1</b>	<b>-1</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>2</b>
TOTAL SHORTFALL	227	214	224	223	232	244

### How does the analysis inform the Plan?

South Australia would require an additional 242 publicly funded beds across the residential, and hospital or aged care sectors and two extra private sector mental health beds.

Whilst there is growth predicted for the sub-acute and non-acute bed types, 80 and 240 respectively, there is a reduction of some 78 acute beds. The source of funding depends on the bed type.

Acute public beds are always provided by the State, and funded as part of Commonwealth and State Health Funding agreements (COAG 2018). As such decisions about hospital bed numbers are made by the State.

In contrast, long-term public places for older people may be funded through Commonwealth aged care, which may then also have State clinical support. For people with severe, very severe or extreme behavioural and psychological symptoms of dementia, the support may be funded by either Commonwealth or State or combined programs.

The National Disability Insurance Scheme (NDIS) also must be considered when interpreting the modelling as this scheme funds supports for people receiving 24 hour care in the community. The existing state funding for the majority of these consumers 24 hour support needs is then transferred from the state mental health budget to the NDIS. Such places replaced the historical long term open mental health beds in stand-alone psychiatric hospitals. NDIS funding is a positive development as these support packages will now be allocated on the basis of need and are uncapped which was not the case in the past.

By 2026 it is estimated that the number of people 65 and older years will increase by 27%. A much larger number of sub-acute and long term residential beds will be required for this age group, and SA currently has a low base.

Whilst the Framework predicts a growth in the sub-acute and non-acute bed types, 80 and 240 respectively, it also predicts a net reduction of 78 acute beds.

The main growth areas for the public sector are 16 additional child and adolescent beds, 33 adult beds and 193 older person beds. The latter being reflective of the change in population demographics. If this modelling were accepted, there would be a closure of 96 adult acute beds that would be replaced by 129 longer term beds for adults.

#### **Child, adolescent and youth beds**

- > By 2026 it is estimated that the number of young people aged 5-17 years will increase by 9.5%
- > South Australia is lower than the national average with 3.3 child and adolescent inpatient beds (acute and non-acute) per 100,000 compared to the national average of 5.1 beds per 100,000
- > SA does not have any inpatient acute or sub-acute youth beds

#### **Older Persons beds (65 years and over)**

- > By 2026 it is estimated that the number of people 65 years and older will increase by 27%
- > A much larger number of non-acute and sub-acute and long term beds as well as beds in residential aged care facilities will be required for this age group

### **Implications for the Plan**

Consensus opinion in the development of the Plan is that closing a net 78 adult acute beds and replacing them with an approximately equivalent number of long term beds is not recommended based on the current state of services and system demands. Many of the people requiring long term beds should be eligible for NDIS psychosocial disability support with high levels of service provided within a residential or group accommodation setting, so this should be addressed without replacing acute beds with long stay non-acute places.

These 78 acute inpatient beds would continue to operate, yet it is anticipated that the demand for these beds would reduce with the implementation of the proposed new crisis system, greater access to long term support for NDIS supported consumers, and access to earlier intervention. It is proposed that acute beds in mental health would be operated flexibly along the lines of beds in medicine and surgery that are open and closed as required, with full transparency of the number of beds opened on any particular day when a service is consistently expected to operate below 85% occupancy. It is expected that by using the 78 acute beds flexibly in the future to attain the 85% occupancy rate that service flow would be improved and this would allow a 15% buffer as services move into the evening shifts to create capacity to manage consumers presenting to emergency department during the night.

So far strategies of increasing bed supply and increasing inpatient turnover have already been applied to the South Australian system yet our ED demand and ED waits remain higher than other states which suggests more inpatient beds alone is not the only solution and community alternatives are required as a next step.

### **The addition of a Crisis Retreat Model to the system**

It is proposed that planning occur for a 20 bed crisis retreat residential centre. This will initially be in addition to existing bed stock and is expected to be operating in the medium term. Based on the limited beds in the north of Adelaide, the first centre would operate in the northern metropolitan area, but be available to take admissions statewide. It is anticipated that a second 20 bed centre could be established in a second metropolitan location with two 10 bed centres established in country SA.

It is expected that ultimately the effective operation of Crisis Retreat beds would allow at least an equivalent number of inpatient beds to close. Any savings from additional bed closures based on the effective operation of two initial Crisis Retreat centres will allow funding to be re-invested to support the opening of country centres as well as supporting extra mobile teams.



## Long term community places

- > Additional subacute places and non-acute places are proposed to be added to the system during the period of the plan using a phased approach.
- > The long term need for high level supported accommodation places should be met through access to National Disability Insurance Scheme support.
- > The intake criteria for Intermediate Care Centres could be adjusted to account for the introduction of Crisis Retreat Centres, as noted with one centre to offer youth sub-acute services and other centres and intermediate care programs to continue to offer adult sub-acute services. However the conversion of an intermediate care centre to develop a youth sub-acute residential unit would be subject to a review of how intermediate care centres are utilised and to ensure that there are no emerging gaps should one of the two adult centres close. If it was not possible to convert an existing adult centre, then a comprehensive business case would be developed for consideration by government and be subject to a needs assessment.

## Oakden Planning

The Framework indicates that South Australia requires an additional 193 older persons beds or places. The planning for older persons residential services has already been announced by the Oakden Response Plan Oversight Committee and includes the following requirements totalling 216 places:

- > Statewide Neuro-behavioural Unit – 24 state funded places of care for management of very severe to extreme behavioural and psychological symptoms of dementia (BPSD).
- > Specialist Residential Care Units – 120 places of care for severe BPSD across metropolitan LHNs, 36 places of care for severe BPSD in regional SA, 36 places of care in metropolitan LHNs for severe and complex enduring mental illness

Currently South Australia has a 16 bed residential unit at Northgate and as a consequence, South Australia would require an additional 200 beds and places which is in accordance with the Framework's 193 beds. The government has already announced an 18 bed Neuro-behavioural unit at the Repatriation Health Precinct site. A further 12 beds are planned for a similar unit in Northern Adelaide in 2021-22.

The Specialist Residential Unit (SRU) model is proposed as a partnership between SA Health and an approved aged care provider, identified through a tender and contracting process and be eligible for Commonwealth aged care funding. The approved provider will lead accreditation processes under the Aged Care Standards.

The SRU model for dementia has now been superseded by the Commonwealth's Specialist Dementia Care Units which is a very similar model.

The Oakden Response Plan Implementation Oversight Committee also recommended the development of a Rapid Access Service (RAS) model, providing specialist and responsive in-reach to mainstream residential aged care facilities from our community older persons mental health services within the three metropolitan Local Health Networks and across country locations.

While it is anticipated that residential beds for people with extreme behavioural and psychological symptoms of dementia will be operated by the state government, other beds for people with severe or very severe symptoms will receive Commonwealth aged care funding with additional state support. A key state focus will be on increasing older person mental health clinicians to provide support to those units and also the community generally.

## Forensic Mental Health

At this current time the Framework cannot be used to predict forensic bed numbers, the requirement for which depends not only on clinical need, but decisions by Courts related to the mental impairment defence and fitness to plead, and when release into the community on licence can be granted. In South Australia, the forensic mental health facility is also used as a facility for forensic consumers who experience a disability, but may not have a mental illness.

Based on current demand, acute forensic beds need to increase from a current 50 beds to 80 beds by the conclusion of the Plan. If supplemented by other programs such as forensic court diversion and community forensic mental health care, the 80 beds are likely to be sufficient; however any facility would need to be designed with a future expansion capacity in mind. The current main building of James Nash House which caters for 30 consumers is dated, not conducive to contemporary care, and needs to be demolished and replaced. A rebuilding program could occur over a number of years in the medium to long term – initially building replacement beds at the current James Nash site, followed by additional beds.

## Current Mental Health Funding in South Australia 2018-19

The current mental health operating expenditure budget is \$423.1 million and is spread across local health networks and DHW as follows:

- > Central Adelaide Local Health Network – \$106.4 million;
- > Northern Adelaide Local Health Network – \$96.6 million
- > Southern Adelaide Local Health Network – \$85.1 million
- > Women’s and Children’s Health Network – \$38.3 million;
- > Country Health SA Health Network – \$53.9 million
- > Non-Government Services – \$36.0 million; and
- > Department for Health and Wellbeing – \$6.8 million

### TOTAL - \$423.1 million

The mental health budget is part of the integrated health budget and this expenditure is the direct operating costs, but may not capture all mental health expenditure as a result of multi-use cost centres and centralised support systems.

The following graph depicts the changes in mental health funding across care types for the past ten years. The community sector has experienced the largest growth in funding over the period.

## Mental Health Funding per Capita

The national average mental health funding on a per capita basis is merely an average only, reflecting expenditure outlaid not actual need.

For core services categories such as general adults, child and adolescents, youth, older persons and forensics, South Australia expended \$229.39 per capita compared to the national average of \$202.88 per capita, or about 13% more than the national average.

One of the challenges in the development of the Plan was to examine how existing funding could be used more effectively, while recognising that investment in new initiatives will be needed to achieve a more integrated, efficient and sustainable mental health system into the future.

## Emergency Departments

Overall mental health presentations to an emergency department represent about 4% of the total emergency department presentations.

During the period 2014-15 to 2017-18, mental health presentations to emergency departments increased by 21%, from about 16,800 to 20,300.

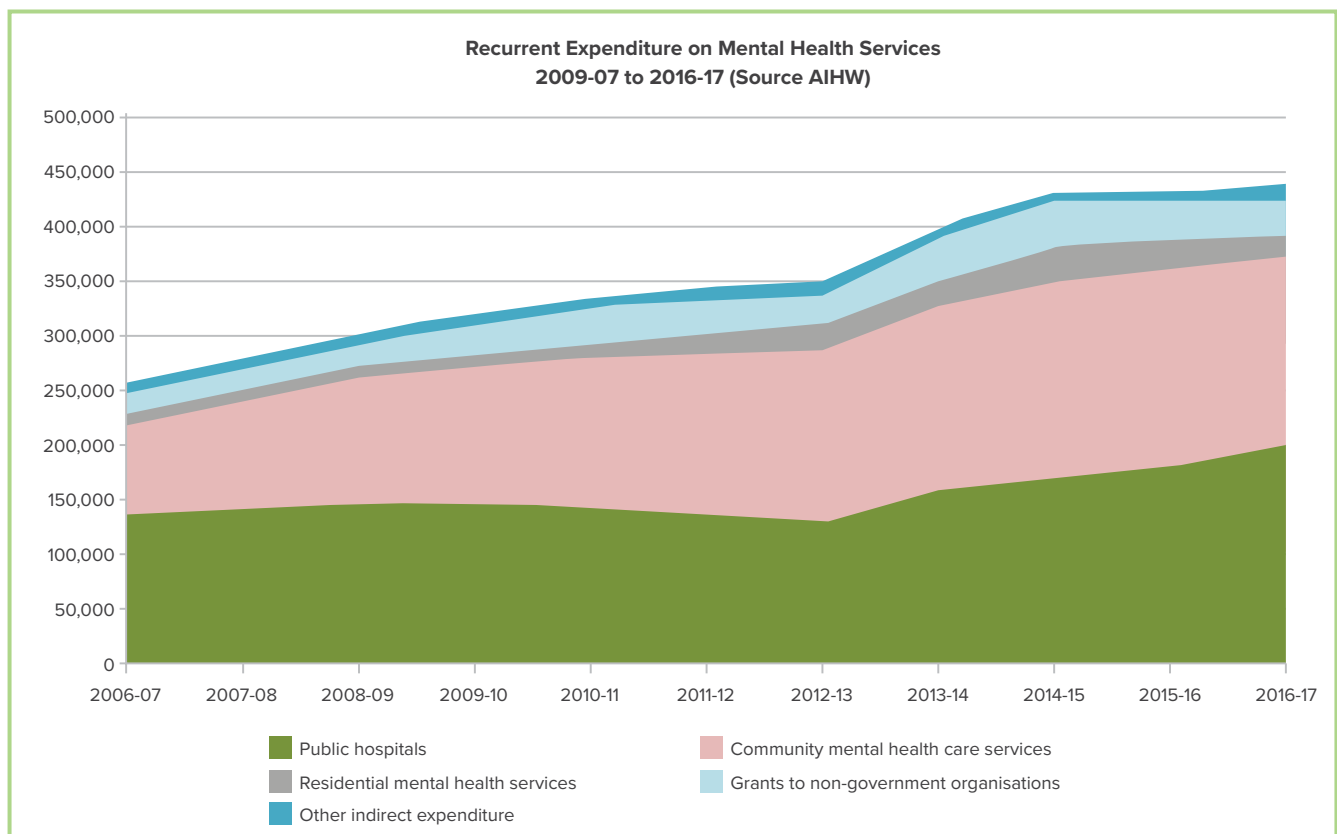


Figure 5: Recurrent Expenditure on Mental Health Services 2006-07 to 2016-17

People presenting to an emergency department are triaged using the Australasian Triage Scale Categories with associated maximum waiting times for medical assessment and treatment:

1. Resuscitation (immediate)
2. Emergency (10 minutes)
3. Urgent (30 minutes)
4. Semi-urgent (60 minutes)
5. Non-urgent (120 minutes)

For 2017-18, approximately 70% of people are assessed at presentation to be in the first three categories, with the Urgent category being the largest at 55%.

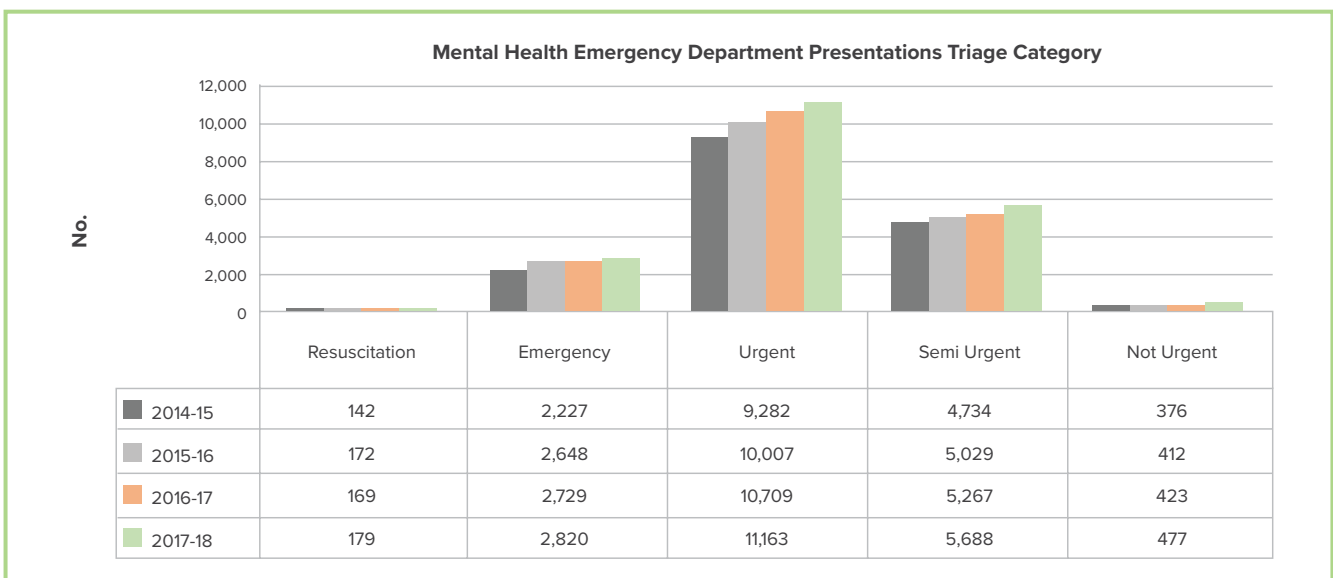


Figure 6: Mental Health Emergency Department Presentations Triage Category

In 2017-18 approximately 30% of people who present to an emergency department were assessed as non-urgent. Contributing factors could include:

- > the out of hours nature of the presentation;
- > the person has no link with a general practitioner or other alternative services;
- > the cost of accessing services elsewhere; or
- > limited alternative options may also include community mental health services having insufficient capacity and accessibility out of hours

Approximately 46% of mental health consumers arrive at an emergency department by ambulance, with approximately 23% of people arriving being triaged as non-urgent. Reasons for this could include having limited options for alternative transport to seek timely treatment, or concern by the consumer, families and carers about the crisis and level of need for the consumer.

### Emergency Department waiting times

The current high rate of presentations to emergency departments compared to other jurisdictions represents a failure to deliver effective community alternatives. As described in this Plan it is proposed that mobile emergency support would be expanded, initially in partnership with ambulance and police, and then with increased mobile mental health teams.

## Major Metropolitan Emergency Department Presentations 2018 (excludes WCH)

	Mental Health	Drug & Alcohol	Rest of Health	Grand Total
Presentations	15,825	4,516	345,812	366,153
% Presentations	4.32%	1.23%	94.44%	100.00%
Visit Hours	11.1	8.3	4.9	5.2

Early in the Plan it is proposed that an Urgent Mental Health Care Centre be established, accepting self-presentations and ambulance referrals up to triage level 3 (urgent). Based on existing presentation data up to 17,328 of 20,300 presentations would be eligible to attend an Urgent Mental Health Care Centre, although this is a statewide figure, and the first centre would operate in the CBD. Such a centre would provide a more therapeutic environment than existing emergency departments. It is expected to be preferred by consumers, possibly leading to earlier presentations and avoiding later emergencies.

Also although Acute Behavioural Assessment Units (ABAU) are not a part of the Framework, the Plan proposes that Mental Health services, Drug and Alcohol Services and Emergency Medical Care work in partnership to develop an ABAU. This would fast track the care of consumers experiencing behavioural disturbance secondary to drug and alcohol use, mental illness, or psychosocial crisis. It is proposed that an initial six bed unit would be planned within the short term and be established in a metropolitan hospital within the medium term to trial the concept. This will be followed by at least two further metropolitan units, and the development of protocols to be used by ED staff and mental health in larger rural centres with telemedicine support from metropolitan ABAUs.

### Suicide Prevention

Mindframe advises when exploring data relating to suicide that it is important to remember that behind the numbers are people, families and communities impacted by suicide in Australia. The reasons people take their own life are often complex (Mindframe 2018)

This summary of the data about intentional self-harm deaths is derived from the Causes of Death, Australia released by the Australian Bureau of Statistics (Catalogue 3303.0 September 2018).

The ABS advises that care should be taken in comparing 2017 data with:

- > previous years – some data has been subject to quality improvement processes
- > prior to 2006 – this data was not subject to the revision process
- > due to the relatively small numbers of intentional self-harm deaths in some states and territories, even one or two deaths can have a significant impact on standardised suicide rates.

### South Australia in 2017:

- > recorded 224 deaths by intentional self-harm (225 deaths recorded in 2016)
- > recorded the third lowest age-standardised intentional self-harm death rate (12.8 per 100,000). The national average was 12.6 deaths per 100,000 of population
- > the age-standardised intentional self-harm death rate for men (18.8 per 100,000) was lower than the rate observed in 2016 (19.6)
- > the age-standardised rate for females (7.0 per 100,000) was also lower than the rate observed in 2016 (7.2 per 100,000 of population).

### South Australian Age-standardised intentional self-harm death rate in 2017 shows:

- > greater Adelaide had a lower rate, when compared to the rest of SA
- > greater Adelaide had a slight decrease in the age-standardised rate for 2017 (11.5 per 100,000) compared to 2016 (13.3 per 100,000)
- > the rest of SA (country) saw an increase in 2017 (18.3 per 100,000) compared to 2016 (13.5 per 100,000).

### Aboriginal and Torres Strait Islander peoples in South Australia from 2013-2017:

- > the standardised death rate for Aboriginal and Torres Strait Islander peoples (25.0 per 100,000) was double the rate for Non-Aboriginal people (12.7 per 100,000)
- > the standardised death rate for Aboriginal and Torres Strait Islander peoples was 24.9 per 100,000 for SA compared to the national average of 25.0 deaths per 100,000 of population.

## Implications for the Plan

The plan proposes service responses to reduce suicide by known consumers, which will link to broader suicide prevention measures that emanate from the State Suicide Prevention Plan and the work of the Premier's Council on Suicide Prevention. These include the roll out of a Towards Zero suicide clinical practice improvement initiative to all South Australian mental health services across metropolitan and country South Australia.

Components of such an initiative would include improvements in assessment, engagement, follow-up and support, as well as service re-design that improves safety. New standards for follow-up would be developed within 18 months that would require follow-up of all people who have been discharged from an emergency department, Crisis Retreat Centre, Urgent Mental Health Care Centre or inpatient unit within 3 and 7 days. The latter strategies and the design of associated follow-up services will be based on emerging evidence from studies in Australia (for example Black Dog Institute 2018, and Beyond Blue 2019) and work underway on new UK National Institute of Clinical Excellence guidelines.

## The Bed Debate

The Coroner has called for a fourfold increase in beds (State Coroner 2018). In a follow up article an author argued for an increase in public sector psychiatry beds to 50 per 100,000, and that a decrease in availability of specialist psychiatric beds may have led to an increase in suicide rates in the community (Medic SA, 2018).

The funding of such an increase in beds would create an enormous opportunity cost and risk an unbalanced stepped model with a focus on hospitalisation for adults at the expense of a broad range of therapies and community models.

What is not in dispute is that people who need inpatient care should have access to a bed when required.

As stated earlier in the Plan, a marker of the effectiveness of the Plan will be reduced waits for beds, and improved access to community alternatives.

A 2015 Community Mental Health report by Deloitte identified that core business of community mental health is ill defined and ill focussed, with variations in clinical care and models, and concerns that the current design was not matching clinician's skills with consumer needs. LHNs are now addressing these issues with their own internal redesign. These considerations are relevant in weighing up the current performance of community mental health and inpatient services.

In July 2017, post the Chief Psychiatrist's Oakden Investigation, a report was prepared by Fjeldsoe et al entitled the Audit of Recommendations Arising from Recent Reviews and Accreditation Surveys (Fjeldsoe et al 2017). In that report the authors make the following comment –

*There is evidence that clinical and non-clinical programs delivered in the community have been in a state of decline as resources have been directed to hospital based service development to respond to the bed flow and access challenges of 2015. While it is beyond the scope of this present audit to conduct a comprehensive analysis it seems that the range of community based programs which would normally be expected to divert consumers from emergency departments and reduce the length of stay for those admitted have been significantly diminished. These include services provided by the non-government sector and public sector clinical services provided by community teams. In metropolitan LHN's, levels of integration and co-ordination across adult programs appear to have deteriorated significantly.*

*Services provided in the community currently do not appear to consistently include those components which would normally be associated with a contemporary community mental health service. There is clear evidence that staff working in the community are unclear about their roles and are disconcerted by recent changes. The development of a new state plan for mental health service reform should be informed by a contemporary recovery oriented approach with a strong focus on the development of community based alternatives to inpatient care.*

Community mental health and inpatient services are both important and need to be nurtured and supported for the benefit of clinical care that is safe and effective.

# 5. Outcomes and measures

## 5.1 Eleven service outcomes and their proposed actions and measures

The eleven service outcomes are summarised in table form, these are explained in further detail in the following sections.

<b>Personalised Care</b>		
<b>Outcome 1 – People receiving services are actively engaged as partners in their care</b>		
<b>KEY ELEMENTS</b>	<b>HOW WILL THIS BE ACHIEVED?</b>	<b>MEASURES OF SUCCESS</b>
<ul style="list-style-type: none"> <li>&gt; People experience mental health care as active and valued participants, with care plans developed in partnership with the person and the people that care for and/or about them.</li> <li>&gt; People have an agreed set of care goals that guide comprehensive clinical decisions and the recovery journey and are clear as to who has overall accountability for their care.</li> <li>&gt; Trauma-informed approaches and human rights are embedded in all aspects of mental health care.</li> <li>&gt; People have access to personalised care including affordable options for a range of different therapies that extend beyond generic case coordination and medication and are shaped around individual needs and preferences.</li> <li>&gt; People with a lived experience are represented and supported in all levels of service design and delivery.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; A commitment to personalised mental health care service design and delivery will be driven by governance and leadership, clearly outlined in the commissioning of services and is expected to be reflected in local models of care.</li> <li>&gt; Services will be commissioned, designed and delivered on the basis of maximum engagement with consumers and those who care for and/or about them.</li> <li>&gt; Clinicians and peer workers will support consumers to identify personal goals, make decisions about their health and to exercise choice and control.</li> <li>&gt; Training to assist staff with supporting the decision-making capacity of consumers will be available to all clinicians and peer workers.</li> <li>&gt; To enable choice and control, funded mental health services will provide an agreed breadth of evidence-based therapies and intervention from which a consumer can choose.</li> <li>&gt; The employment of peer workers in all funded services will facilitate personalised care.</li> <li>&gt; Apps will be available that support monitoring of conditions, storage of care plans, and communication with staff. The focus will be on providing apps that complements face-to-face care rather than replace it.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Assessing and measuring effective care and support from the consumer's and carers perspectives using the Your Experience of Service (YES) survey and Carer Experience of Service (CES) survey.</li> <li>&gt; Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs, including cultural and linguistic needs (YES survey).</li> <li>&gt; Proportion of people receiving services who report their individual needs and values were respected and incorporated in their care (YES survey).</li> <li>&gt; Evidence of an improvement in people's ability to manage their day to day needs and actively participate in their chosen community using the National Outcomes and Casemix Collection (NOCC).</li> <li>&gt; Proportion of people receiving services reporting they had opportunities for family and carers to be involved in their care if they wanted (YES survey).</li> <li>&gt; Rate of care plan reviews completed every 90 days (or sooner), in partnership with the consumer.</li> <li>&gt; Clinical supervision arrangements are in place for all staff that focuses on skill development and application of personalised care.</li> <li>&gt; All consumers will have access to a peer.</li> </ul>



## Personalised Care

### Outcome 2 – Perinatal, infants, children and families have improved access to and engagement with mental health services and support

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; All mental health services focus on early intervention and prevention .</li> <li>&gt; All mental health services provide a holistic, developmental, family-based approach, where appropriate.</li> <li>&gt; Where possible, mental health care is provided in an environment that best suits the child and family/ caregivers needs.</li> <li>&gt; Mental health services work in partnership with other key agencies to ensure that whole-of-child and family needs are supported.</li> <li>&gt; Therapeutic engagement and continuity of care remain at the core of service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Additional funding for specialist clinical child and youth services to support children and families in the early years.</li> <li>&gt; Embedding specialist mental health staff in other government and NGO services such as child protection, child and family health services, and education settings will enable earlier assessment and engagement.</li> <li>&gt; Additional staffing and expanding the role of Crisis Telephone support to enable a clear and timely point of entry to child and adolescent services, to youth services, and other services which best suits the needs of children and their families.</li> <li>&gt; Recurrent funding to provide leadership and sustainable child and adolescent mental health services to the APY Lands. Increasing the Aboriginal mental health workforce to enable the provision of culturally appropriate mental health care and empowering and building the capacity of the local community.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Increased access to mental health care for children (and their families) identified as developmentally vulnerable in the Australian Early Development Index (Fifth Plan Domain 1).</li> <li>&gt; Proportion of Aboriginal children in SA schools at high risk of clinically significant problems related to behaviour and emotional wellbeing who receive a mental health service.</li> <li>&gt; Proportion of children experiencing stable or improved clinical outcomes through the use of National Outcomes and Casemix Collection (NOCC).</li> <li>&gt; Improved screening and early intervention for parents and families with mental health needs during the perinatal period, including participation in parenting support programs.</li> <li>&gt; Increase in mental health service contacts delivered in the home and/ or in an environment that best suits the child and their family’s needs.</li> <li>&gt; Partnership agreements with key agencies, supporting CYPMHS clinicians embedded in other settings.</li> </ul>

## Personalised Care

### Outcome 3 – Young people (12-24) have positive mental health and access to early intervention services for any emerging mental health issues

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Earlier intervention for young people displaying the signs and symptoms of mental illness, including eating disorders.</li> <li>&gt; Youth less than 16 years of age have easier access to service and support, through embedding CYPMHS staff with other relevant services and other partnership strategies.</li> <li>&gt; Services for young people will be commissioned to the age of 24 years.</li> <li>&gt; Services for young people will be provided in a youth friendly and developmentally appropriate environment to enhance engagement.</li> <li>&gt; Enabling better access to services for young people and their families through a common entry point.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Provide an integrated gateway for youth to access state and youth-friendly services and promote service access through education and other sectors.</li> <li>&gt; Develop formal partnerships with other agencies that support better service integration and the delivery of early intervention services.</li> <li>&gt; Develop consistent models of care across all LHNs that explain access pathways, key transition points, roles and accountabilities and strategies for maintaining continuity of care.</li> <li>&gt; Increase timely access to evidence based health information, screening, and supportive web-based video conferencing to complement face to face care.</li> <li>&gt; Improve the mental health outcomes for young people who are experiencing early signs of, or recovering from, serious mental illness, through the provision of appropriate youth and recovery-oriented care in a youth-friendly, therapeutic environment.</li> <li>&gt; Establishment of a Youth sub-acute service will be considered in the medium term.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Increased access to services for young people (aged 12-24 years) identified as developmentally vulnerable as per the Australian Early Development Index (Fifth Plan Domain 1).</li> <li>&gt; Increased access to community-based options for 12-24 year olds.</li> <li>&gt; A reduction in suicide statistics for 12-24 year olds, including young people from population groups that may be more at risk.</li> <li>&gt; Rates of mental health follow-up after suicide attempt/self-harm (day 3 and day 7).</li> <li>&gt; Proportion of young people recovering from mental illness supported into or resuming employment and/or education.</li> <li>&gt; Reduced waiting lists for young people (aged 12-24 years) being connected with a service.</li> <li>&gt; Services to be informed by relevant data collected through surveys already being completed by other agencies.</li> </ul>

## Personalised Care

### Outcome 4 – Aboriginal people have access to culturally safe and appropriate initiatives determined by local communities

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Reduced risk factors for mental illness, with a particular focus on preventing and addressing issues of loss, trauma, incarceration, violence and substance misuse.</li> <li>&gt; Increased awareness across Department services of the impact of cultural issues on the social and emotional wellbeing of Aboriginal people.</li> <li>&gt; Aboriginal people experience less racism and discrimination as consumers of mental health services.</li> <li>&gt; Reduced suicide and self-harm for Aboriginal people receiving mental health care in secure environments.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; The development of an Aboriginal Mental Health and Wellbeing Centre to improve access to, and engagement with, culturally safe and appropriate services, including access to traditional healers.</li> <li>&gt; The development of targeted early intervention and suicide prevention programs for Aboriginal people in both metropolitan and remote areas.</li> <li>&gt; Improved partnerships between DHW and Aboriginal Community Controlled Health Services.</li> <li>&gt; Increased access to culturally appropriate training for DHW staff, including training programs such as Connecting with People.</li> <li>&gt; The development and implementation of culturally appropriate care planning tools .</li> <li>&gt; Attraction and retention of Aboriginal Mental Health staff.</li> <li>&gt; Improved access to interpreters.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Increased access and engagement with services for Aboriginal people with mental health needs through the Aboriginal Mental Health and Wellbeing Centre.</li> <li>&gt; A decrease in the number of Aboriginal people in South Australia recovering/recovered from mental illness reporting high or very high psychological distress (NOCC data or other culturally appropriate tools).</li> <li>&gt; Proportion of Aboriginal people receiving mental health services experiencing stable or improved clinical outcomes (NOCC data or other culturally appropriate tools).</li> <li>&gt; Workforce participation in culturally appropriate training.</li> <li>&gt; Culturally appropriate care planning tools used across mental health service delivery.</li> <li>&gt; Increase in Aboriginal Mental Health Workforce.</li> </ul>

## Personalised Care

### Outcome 5 – Older people (over 65 or over 50 for Aboriginal people) have access to mental health programs and support that reduce impacts of mental illness

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Aligned with existing strategies and South Australia's Ageing Plan 2014-19, older people receiving DHW services are supported to participate fully in their communities and develop and maintain social connectedness.</li> <li>&gt; Increased availability, promotion and uptake of mental health programs that support mental wellbeing in older people, particularly for people with diverse cultural and language needs.</li> <li>&gt; Availability of in reach programs to support people experiencing significant distress in registered aged care facilities.</li> <li>&gt; Services will work in partnership to improve older persons access to, and engagement with, mental health and general health care at a time and place that best meets their needs.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Increased partnerships between mental health and general health and wellbeing services for older people.</li> <li>&gt; The development of a Rapid Access Service (RAS) to provide specialist and responsive in-reach care to mainstream residential aged care facilities from Community Older Persons Mental Health Services.</li> <li>&gt; Following on from the Oakden review recommendations (Groves et al., 2017), the development of 24 places across two locations to provide care for older South Australians experiencing extreme behavioural and psychological symptoms of dementia (BPSD).</li> <li>&gt; Increased partnerships between older person's mental health services and multicultural services to improve access and engagement for people from CALD backgrounds.</li> <li>&gt; Increased access to psychosocial support services for older people.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Increased access to holistic mental health care for older people in residential aged care facilities, including clinical and psychosocial support.</li> <li>&gt; A decrease in the proportion of older people in South Australia reporting high or very high psychological distress, people with diverse cultural and language needs (NOCC data).</li> <li>&gt; Increased proportion of people with complex BPSD receiving care in appropriate care facilities.</li> <li>&gt; Proportion of people receiving services who report their individual needs and values were respected and incorporated in their care, including opportunities for family and carers to be involved (YES survey).</li> <li>&gt; Assessing and measuring effective care and support from carers perspectives, where appropriate (CES) survey.</li> <li>&gt; Evidence of an improvement in people's participation in daily activities in their chosen community using the National Outcomes and Casemix Collection (NOCC).</li> </ul>

## Integrated Care

### Outcome 6 – People obtain timely and effective mental health care and support that promotes wellbeing and respects diversity

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Clearer pathways to accessing mental health care in a least restrictive environment that best meets the person’s needs, including at home, in clinics and in community facilities as an alternative to hospital-based services.</li> <li>&gt; Mental Health service design that improves human rights and supports people to recover in the community</li> <li>&gt; People in South Australia are supported to have timely access to acute mental health services where appropriate.</li> <li>&gt; Use of technology as a tool to compliment service engagement and enhance consumer experience, particularly for young people and those who have difficulty accessing mental health services.</li> <li>&gt; Services will focus on improving mental health literacy and communication to enhance people’s access to and engagement with mental health services, including people with diverse language and cultural needs.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; The development of alternative access points to care provided in supportive and therapeutic environments, for example, Urgent Mental Health Care Centre and the Safe Haven Café models.</li> <li>&gt; The use of technology to enhance engagement and care outcomes for consumers and staff, including the use of digital health tools and mobile applications to complement face to face care.</li> <li>&gt; Mental health staff (including peer workers) embedded in SA Ambulance Services and police to provide a collaborative 24/7 response to people in the community with increasing mental health needs.</li> <li>&gt; Partnerships with multicultural services to improve access and engagement for people from CALD backgrounds, including the use of accredited interpreters and cultural liaison staff.</li> <li>&gt; Enabling more streamlined access to psychosocial support services in the community.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs (YES survey) and Safety and Learning System (SLS) reporting.</li> <li>&gt; Proportion of people receiving services who report their individual needs and values were respected and incorporated in their care, including family and carer involvement where appropriate (YES survey).</li> <li>&gt; A decrease in the number of people reporting very high levels of psychological distress (NOCC data.)</li> <li>&gt; Reduced waiting times for access to services.</li> <li>&gt; Rate and duration of post-discharge follow-up from inpatient and community mental health services.</li> <li>&gt; Reduction in hospital admissions and readmissions.</li> <li>&gt; Partnerships with multicultural services and an increase in engagement with interpreters.</li> <li>&gt; Assessing and measuring effective care and support from carers perspectives, where appropriate (CES survey).</li> </ul>

## Integrated Care

### Outcome 7 – Services work together in partnership to provide a coordinated response to meet people's individual needs

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Information is shared when and where it is needed to support the best care.</li> <li>&gt; The transition between community and hospital based care is coordinated.</li> <li>&gt; Drug and alcohol services and mental health services work together to jointly contribute skills and expertise supporting people with comorbidities.</li> <li>&gt; The transition from child and adolescent services to adult, and adult to older person's services is seamless.</li> <li>&gt; Mental health services partner with a broad range of sectors to support a holistic approach to people's mental health and wellbeing.</li> <li>&gt; Mental health services recognise the social and structural determinants of health such as housing, education, employment, health care and community services that impact on mental health and wellbeing.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; A decision based tree will be developed based on existing information sharing models to provide simple and practical guidance to staff.</li> <li>&gt; Collection and reporting on comprehensive data, including service experience and outcomes from the consumer's perspective.</li> <li>&gt; Use of collaborative assessment tools across mental health services.</li> <li>&gt; Embedding multi-disciplinary mental health services in other settings, including drug and alcohol services, prisons and aged care facilities.</li> <li>&gt; Work in partnership with Primary Health Networks (PHN) and other key agencies to promote clarity of care pathways between primary, secondary and tertiary mental health care.</li> <li>&gt; Ensure that people with a psychosocial disability who are deemed ineligible to receive NDIS funding are supported to access appropriate care.</li> <li>&gt; Mental Health Co-morbidity workers will be engaged to build capacity within mental health teams.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Enhanced partnership arrangements with other services, including clear referral pathways.</li> <li>&gt; Number of care plans developed in partnership with the consumer, their family/carer and other services where appropriate (YES survey).</li> <li>&gt; Evidence of regular review meetings involving the consumer, their family/carer and other care services where appropriate.</li> <li>&gt; Increased access to mental health services (service contacts) for people in other settings.</li> <li>&gt; Proportion of consumers actively connected with other services including GPs, general health, employment or education, accommodation, and other services.</li> <li>&gt; Assessing and measuring effective care and support from carers perspectives, where appropriate (CES survey).</li> </ul>



## Integrated Care

### Outcome 8 – People living with a mental illness will have better physical health and live longer

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Consumers experience a more holistic approach in seamless service delivery and care planning, recognising the interrelatedness of mental and physical health.</li> <li>&gt; Integrated and transparent care planning and service delivery which recognises and addresses consumer's broader health needs.</li> <li>&gt; Strong partnerships are promoted in coordinating services around the health and mental health needs and preferences of individuals.</li> <li>&gt; Population groups who may be more at risk will have access to better integrated service to address their diverse mental health and health needs.</li> <li>&gt; Veterans at points of entry to the health system are identified as articulated in the 2016-2020 Framework for Veterans' Health Care (SA Health 2016).</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Improved integration and referral pathways between mental health services and general health service providers, including embedding mental health services into other settings.</li> <li>&gt; Improved systems and processes in place to collect and report on general health needs for people engaged with mental health services.</li> <li>&gt; State, commonwealth (PHNs), GPs, NGOs and people with a mental illness to co-design a state-wide policy relating to the integration of mental health and physical health services, including clarification of responsibilities between and within primary care and all mental health services.</li> <li>&gt; Improved physical health screening, monitoring protocols and clinical guidelines for a wide range of mental disorders, maintaining a whole-of person approach, and aligning practice with the WHO Comprehensive Mental Health Action Plan (WHO 2013).</li> <li>&gt; Ensuring that consumers receive cardio metabolic monitoring when on antipsychotic medication, followed by effective, evidence-based interventions.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Proportion of people receiving mental health services who are actively engaged with a GP and other health services based on their individual needs, including cardiovascular (CVD) screening, dental care, optical care, diabetes care.</li> <li>&gt; Proportion of people receiving mental health services who have access to allied health care, including exercise physiology, dietetics, podiatry, physiotherapy, occupational therapy, audiology, clinical and health psychology.</li> <li>&gt; Decreased prevalence of chronic health conditions for people accessing mental health services.</li> <li>&gt; The collection of general health information included in routine assessments, care planning and clinical reviews.</li> <li>&gt; Enhanced partnership arrangements with other health services, including clear referral pathways and collaborative care planning.</li> </ul>

## Safe and High Quality Care

### Outcome 9 – Improving safety and quality in mental health services to reduce harm, uphold human rights and support inclusion

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; People identified by mental health services as at increased risk of suicide and/or self-harm will be actively supported.</li> <li>&gt; Quality improvement initiatives that reflect consumer and community needs and expectations.</li> <li>&gt; Trauma informed and recovery oriented care is integral to mental health service delivery.</li> <li>&gt; A strong values structure and cultural sensitivity are evident in the practice of all mental health care providers.</li> <li>&gt; All mental health services have a strong focus on least-restrictive care.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; A full review of personal care needs and preferences will be undertaken for all people receiving care in a hospital environment for longer than 35 days.</li> <li>&gt; The establishment of a Towards Zero Suicide Clinical Practice Improvement Initiative.</li> <li>&gt; Evidence-based approaches and strategies relating to suicide prevention and trauma informed care embedded in all aspects of mental health service delivery.</li> <li>&gt; DHW policy directive and guidelines for Sexual Safety in Mental Health Services implemented.</li> <li>&gt; Chief Psychiatrist inspections to be carried out to uphold community expectations and regulatory obligations for quality and safe service provision.</li> <li>&gt; People with a lived experience will be engaged to participate in Chief Psychiatrist inspections and any service reviews.</li> <li>&gt; Services will work in partnership with consumers and their carers/families to explore and manage risks in a collaborative way.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Evidence of Clinical Practice Improvement projects focusing on Towards Zero Suicide being facilitated and implemented in services.</li> <li>&gt; Connecting with People and Trauma Informed Care training delivered to staff, with evidence of approaches seen in clinical practice and documentation.</li> <li>&gt; A reduction in the number of suicides for people receiving mental health care and treatment (DHW services).</li> <li>&gt; Chief Psychiatrist inspections completed.</li> <li>&gt; A reduction in the incidence of any form of restraint/seclusion/exclusion.</li> <li>&gt; Mental health services meet the targets set out in the National Safety and Quality Health Service Standards (ACSQHC, 2017).</li> <li>&gt; A reduction in the number of incidents in mental health services, measured through the use of the Safety and Learning System.</li> </ul>

## Safe and High Quality Care

### Outcome 10 – Mental health services promote fairness, inclusion, tolerance and equity in all interactions

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; Government and NGO mental health services and their collaborators aspire to be the leaders in promotion of de-stigmatisation and the value of people with lived experience of mental illness in our communities.</li> <li>&gt; Mental health services work in partnership with general health and other services, with better collaboration and training of non-mental health staff to better respond to mental health needs of consumers.</li> <li>&gt; Mental health services will be underpinned by a culture where poor staff behaviours are challenged.</li> <li>&gt; People's previous history or behaviours are not a constant feature, nor a barrier, in their access to or engagement with services.</li> <li>&gt; Reducing stigma and discrimination and improving services is a vital part of improving outcomes for vulnerable population groups.</li> <li>&gt; A culture of openness, transparency and compassion supports staff to feel safe.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Clear leadership and governance that drives a positive culture across all aspects of mental health service delivery, ensuring inclusion and equity are reflected in practice, including for staff and consumers from population groups who may be at increased risk of discrimination.</li> <li>&gt; Embedding peer workers in all aspects of mental health service design and delivery, including the evaluation of services and programs.</li> <li>&gt; Consumer and carer feedback will be actively sought and used to inform service improvement, including experiences of stigma and discrimination.</li> <li>&gt; Workforce strategies will emphasise values-based recruitment, incorporating principles of diversity, inclusion, equity and compassion.</li> <li>&gt; Mental health training developed and delivered in partnership with other key agencies (for example South Australian Ambulance Services, South Australian Police).</li> <li>&gt; Staff have access to ongoing supervision and professional development opportunities, and are supported to highlight behaviours which do not reflect inclusion, fairness and equity.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Proportion of people receiving services who report feeling safe when accessing services and their individual needs and values are respected and incorporated in their care (YES survey).</li> <li>&gt; Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs, including people with diverse cultural and linguistic needs (YES survey).</li> <li>&gt; Staff values, attitudes and behaviours measured through workforce surveys.</li> <li>&gt; A reduction in the proportion of people recovering/recovered from mental illness reporting experiences of stigma, reported in consumer feedback and/or via DHW's Safety and Learning System.</li> <li>&gt; National Safety and Quality in Healthcare Standards are adhered to with the Comprehensive Care Standard being fully met and actively implemented by services.</li> <li>&gt; Assessing and measuring effective care and support from carers perspectives, where appropriate (CES survey).</li> </ul>

## Safe and High Quality Care

### Outcome 11 – The workforce is supported to provide the best care

KEY ELEMENTS	HOW WILL THIS BE ACHIEVED?	MEASURES OF SUCCESS
<ul style="list-style-type: none"> <li>&gt; The use of a professionalised peer workforce is expanded and peer workers are included and respected as part of the mental health team.</li> <li>&gt; A strong focus on training and development to enable the workforce to grow and excel.</li> <li>&gt; Mental health services will reflect a positive culture that is inclusive and respectful of all disciplines as part of the mental health team.</li> <li>&gt; Mental Health services will provide opportunities that attract people to work in mental health.</li> <li>&gt; New and innovative ways of working are supported.</li> <li>&gt; Our people will have a strong and consistent set of core values, skills and abilities.</li> <li>&gt; New graduates will be attracted and supported to work in mental health, ensuring the size, diversity and mix of the workforce is appropriate, and existing staff are supported to maintain and develop new skills.</li> <li>&gt; Access to training and culturally appropriate, accessible resources to enable the workforce to provide appropriate support to people with diverse cultural and linguistic needs.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Clear peer workforce role definitions, competencies, scope of practice and standards will be developed to ensure the workforce has the capability to deliver the best care.</li> <li>&gt; Ensure a peer workforce component is considered for all new initiatives.</li> <li>&gt; The development of a clear governance and support structure for the peer workforce, including supervision and professional development opportunities.</li> <li>&gt; The development of a professional development plan for staff, and managers use the performance review and development process to challenge entrenched behaviours.</li> <li>&gt; Partnerships with the tertiary education sector to determine training and skill needs, and student placements.</li> <li>&gt; Implementation of the new whole of South Australian government Mentally Healthy Workplaces framework.</li> <li>&gt; Ensure mental health leaders and managers have the tools and training to proactively support staff and manage workloads and foster positive culture.</li> <li>&gt; Increase and acknowledge the valuable and skilled Aboriginal mental health workforce.</li> </ul>	<ul style="list-style-type: none"> <li>&gt; Decreased frequency and duration of unfilled staff vacancies.</li> <li>&gt; Increase in student placements facilitated in mental health services, across all disciplines.</li> <li>&gt; Increase in new graduates seeking employment in mental health services.</li> <li>&gt; Number of supervised training positions in DHW's mental health services.</li> <li>&gt; Increase in the number of trained peer worker positions in DHW's mental health services.</li> <li>&gt; Improvements in workforce wellbeing and satisfaction measured through staff surveys.</li> <li>&gt; Decrease in WorkCover injury claims for psychological distress.</li> <li>&gt; Improved recruitment and staff retention rates.</li> <li>&gt; Increased uptake and engagement in staff training opportunities, including peer workforce training.</li> <li>&gt; Increase in the number of Aboriginal Mental Health Staff in mental health services.</li> </ul>

## 5.2 Personalised Care

### Outcome 1: People receiving services are actively engaged as partners in their care

#### What does personalised care look like?

Personalised care is, through its nature and scope, respectful of individual needs and embraces dignity and active participation in care and treatment decisions. It includes engagement in how services and specific therapeutic interventions are developed with the individual and provides connected care with choice and treatment options that are inclusive of family and carers.

#### Measuring personalised care

Traditionally, measurement and evaluation of mental health services has tended to focus on activity and clinical based outcomes. This narrow measurement framework ignores the impact of influential social determinants such as living independently, involvement in part time or full time work and/or active decision making (Procter et al., 2017).

#### What is proposed?

The Plan advocates for the use of personalised outcome measures across mental health and other services to promote a shared care approach when engaging with consumers. Some LHNs in South Australia are already using personalised outcome measures in the Child, Youth and Adult sectors. These measures include:

- > Inspire (2013, UK), an engaging tool that looks at both support and therapeutic alliance as part of the recovery journey
- > Session Rating Scale (Miller et al., 2003), a clinical scale that can be used by both the consumer and clinician capturing four areas of engagement (agreement over goals; approach; quality of relationship; and ensuring the therapeutic sessions match the care recipient's expectations)
- > Recovery Assessment Scale – Domains and Stages (RAS-DS) (Hancock & University of Sydney 2015), a 38 item scale measuring four domains of a consumers' recovery (connecting and belonging; doing things I value; managing my illness; and hope for the future)

- > Recovering Quality of Life (ReQoL) (Keetharuth 2018), 10 or 20 item versions used in care planning and a therapeutic tool to guide treatment outcomes and overall recovery journey.

The Plan supports wider use of these and other clinically recognised tools.

#### How will this be achieved?

- > A commitment to personalised mental health care service design and delivery will be driven by governance and leadership, clearly outlined in the commissioning of services and is expected to be reflected in local models of care.
- > Services will be commissioned, designed and delivered on the basis of maximum engagement with consumers and those who care for and/or about them.
- > Clinicians and peer workers will support consumers to identify personal goals, make decisions about their health and to exercise choice and control. Clinical decisions will reflect the will and preferences of the consumer where possible.
- > Staff will engage with carers, guardians and advocates where appropriate, and facilitate access to peer workers and carer consultants.
- > Training to assist staff in supporting the decision-making capacity of consumers will be available to all clinicians and peer workers.
- > To enable choice and control, funded mental health services will provide an agreed breadth of evidence-based therapies and intervention from which a consumer can choose. The interventions will be consistent with recognised clinical guidelines for the conditions that services commonly assess and treat.
- > The employment of peer workers in all funded services will facilitate personalised care.
- > The use of apps that support monitoring of conditions, storage of care plans, and communication with staff. Apps will be used to complement face-to-face care rather than replace it.

### What are the measures of success?

- > Assessing and measuring effective care and support from the consumer's perspective using the Your Experience of Service (YES) survey.
- > Assessing and measuring effective care and support from carers perspectives, where appropriate, using the Carers Experience of Service (CES) survey.
- > Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs, including cultural and linguistic needs (YES survey).
- > Proportion of people receiving services who report their individual needs and values were respected and incorporated in their care (YES survey).
- > Evidence of an improvement in people's ability to manage their day to day needs and actively participate in their chosen community using the National Outcomes and Casemix Collection (NOCC).
- > Proportion of people receiving services reporting they had opportunities for family and carers to be involved in their care if they wanted (YES survey).
- > Rate of care plan reviews completed every 90 days (or sooner), in partnership with the consumer.
- > Clinical supervision arrangements are in place for all staff that focuses on skill development and application of personalised care.

### Better responses to trauma

A key outcome of the Plan will be better responses to people who have experienced trauma in their lives. Providing early intervention for children and young people at risk, access to therapies for adults who have experienced trauma, and the delivery of mental health care that does not re-traumatise individuals are key priorities.

Trauma informed care and practice (TICP) leads to enhanced therapeutic relationships and can lead to reductions in seclusion and restraint practices (SAMHSA 2014).

Domains of trauma informed practice overlap with other priorities in the Plan. It includes the design of programs that ensure the safety of consumers, maximises the trustworthiness of programs, maximises consumer choice and control, and prioritises empowerment and skill building (Fallot and Harris 2011).

### Why change is needed?

During the development of the Plan there was clear feedback regarding the need to enhance the focus on trauma informed care across mental health services.

### How will this be achieved?

- > Commissioned clinical services will have the capability to assess for the impact of trauma, provide relevant therapies and will be designed not to further traumatise people by avoiding restrictive practices where possible.
- > All care will be delivered and audited against trauma informed care and practice clinical guidelines.
- > Mental health service responses to natural and man-made disasters will be delivered in partnership with Primary Health Network funded Services, be subject to post-disaster reviews after activation of the plan, and yearly preparedness assessments.
- > Trauma informed capability will be increased across services and practitioners with access to training and the implementation of trauma informed strategies.
- > All commissioned inpatient services and mental health services in emergency departments will apply quality improvement models that improve therapeutic engagement and reduce the use of restrictive practices (Safewards or equivalent).
- > In the medium term, the operation of trauma informed practice will be regularly audited with the expectation that effective units will have low use of restrictive practices (and low rates of staff injuries which usually reduce when restraint is avoided).
- > Trauma informed practice will be supported by quality improvement science – including the use of clinical practice improvement to reduce the use of restrictive practice, and an extension of existing communities of practice for frontline staff.

### Provision of step down services for veterans and first responders that are underpinned by a trauma informed and recovery-based approach to care

It is proposed that extra steps for veterans and first responders care system are provided. A "mini-step model" would be explored with a community residential step down and step up facility initially for up to six residents operated as either a stand-alone facility or run in conjunction with an existing facility. The facility will have expertise to manage PTSD and substance use disorders, amongst other mental illness.



Veterans and first responder services will provide sub-specialist expertise in the assessment and treatment of post-traumatic stress disorder and co-morbid illnesses, and will be delivered in the community as individual and group therapies. The service will also provide outreach and consultation to veterans and first responders in other hospitals, prisons or in homelessness services. It will be integrated with the work of private practitioners funded by the Commonwealth Department of Veteran's Affairs.

### What are the measures of success?

- > Therapies to address the impacts of trauma available to consumers of all age groups.
- > Trauma Informed Practice delivered across all Local Health Networks.
- > A reduction in rates of seclusion and restraint in mental health services – there will be improvement in current performance in the short term, a below average use of restrictive practices in the medium term, and national best practice by the completion of the Plan.
- > Increase in peer worker roles across mental health services.
- > High quality post-traumatic stress disorder services will be available to veterans and first responders in the community (in conjunction with private providers), in hospital and at a step-down centre.

### Human rights and recovery

Human rights are inter-related and inter-dependent with access to safe and high quality health care.

***“You can't recover from anything unless you have a bit of the power.”***

*(Feedback from a lived experience participant, MHSP survey 2018)*

### What is proposed?

All of DHW's commissioned services will respect, promote and protect the human rights of every consumer.

### How will this be achieved?

- > A human rights analysis will support the development of the models of care for all new commissioned services. Services will be designed to uphold the dignity and respect for consumers at all times.
- > Education to staff will be provided on the United Nations Convention on the Rights of Persons with Disability and other relevant rights instruments, along with practical steps to uphold those rights. This will be incorporated into orientation programs and continuing education programs. Peer workers will be involved in this education.
- > In conjunction with the focus on personalised care and the reduction in restrictive practices, a concerted drive to reduce the mental health systems current reliance on involuntary treatment will occur during the life of the Plan. This will include early engagement with consumers, early intervention, support to encourage treatment, and a use of orders as a true last resort. The aim will be to reduce the use of involuntary orders to a level that corresponds to best practice internationally.

### What are the measures of success?

- > Values and human rights elements incorporated into service models and delivery.
- > Reduction in the use of restrictive practices and the use of involuntary orders.

## **Outcome 2: Perinatal, infants, children (0-12) and families have improved access to and engagement with mental health services and support**

This Outcome covers:

- > early Intervention
- > integrated Mental Health Services into Child and Youth Settings
- > increased community child and youth mental health services
- > expanding CAMHS triage capability
- > mental health service for children and families in the APY Lands.

Improving the mental health and wellbeing of children and their families, and preventing the development of mental illness is vital to creating a positive and fulfilling life trajectory for young people and future generations. This includes identifying and intervening early, targeting services appropriately and developing models for working with individuals and families with complex needs.

An agreed priority area identified in the Plan is care for perinatal, infant, child (including children of parents with mental illness) and families, recognising the need for a greater emphasis on prevention and early intervention.

### **Early Intervention**

#### **Why change is needed**

Adverse childhood experiences (ACE) are the strongest predictors for the development of mental health and physical health problems in later life. Early adverse experiences have links with alcohol and substance use, social and relationship problems, poor educational and vocational outcomes, and involvement in the criminal justice system (Anda & SAMHSA 2018; Procter et al., 2017). There is evidence that intensive psychosocial interventions delivered at the earliest opportunity can help to ameliorate the detrimental effects of ACEs, changing the life trajectory for infants and their families (Allen, 2011).

The National Perinatal Depression Initiative (NPDl) which ran successfully in South Australia from 2009-2015 was jointly funded by Commonwealth and State governments. Some positive outcomes from this initiative are still in place in all public birthing hospitals. There is now more effective and earlier screening and identification of both antenatal and postnatal maternal mental health difficulties through LHN services and Child and Family Health Services.

#### **What is proposed?**

The National Mental Health Services Planning Framework highlights the need to expand child and youth mental health services.

#### **How will this be achieved?**

Additional funding for specialist clinical child and youth services to support children and families in the early years is crucial to improving mental health and wellbeing in our communities. Additional capacity could address:

- > Perinatal Infant Mental Health Services staff – assessments and therapies available in community settings
- > increase Perinatal Infant Mental Health Services in-reach into birthing hospitals
- > provide an ‘early years’ capacity to support children’s services
- > increased capacity to assist schools, child protection and child and youth corrections
- > increase specialist services for youth, to support and partner with primary mental health youth services and Headspace

#### **Enhancing resources and embedding mental health services in other settings**

The Plan advocates for embedding specialist mental health staff in a range of different service settings to strengthen community capacity and provide a timely response to children and their families. Should the recipient agencies not wish to have staff embedded within their services, these staff would still be required to provide specialist mental health services to children and their families. It is proposed initially that any staff embedded in schools, child protection and child and youth corrections will come from the re-profiling of existing child and adolescent staff allocations. However, should the need arise to create additional capacity to meet service demand; a business case will be prepared for consideration and prioritisation by government.

#### **Why change is needed**

In many cases, mental illness first emerges in the early years, with approximately half of all mental disorders emerging by the time children are 14 years old and three quarters by the age of 25 (Patel et al., 2016). Preventing and addressing any early signs of adversity or mental health concerns during childhood must be prioritised in order to disrupt the health, social and economic impacts later in life.

The Plan acknowledges that children and families who are in contact with the child protection system often have complex needs that require a collaborative multi-agency response, particularly children in out of home care that are living in residential care facilities (AIHW 2018).

## What is proposed?

Embedding specialist mental health staff in other government and NGO services such as child protection, child and family health services, and education settings will enable earlier assessment and engagement.

Child and youth education settings can provide an excellent access point for mental health services, with a range of existing programs that focus on educating students, staff and families on mental health and wellbeing, and building resilience. Embedding mental health staff into these settings will assist with prevention and earlier intervention for children and young people who are more at risk, and provide specialist support to non-mental health staff.

Initially, opportunities for new staff to provide services to children and young people in alternative settings will be explored. Eventually embedded positions and outreach functions will be offered to existing staff, with access to professional support and supervision.

## How will this be achieved?

Enhancing partnerships between specialist child and youth mental health services and other agencies is an essential part of delivering a more integrated service to children and families. Enhancing staffing resources and embedding clinicians in other settings will boost the amount of prevention and early intervention services available to children and their families. Our specialist Child and Adolescent Mental Health Services (CAMHS) would retain clinical governance for mental health staff working within other settings to ensure that appropriate supervision, training and support is maintained for these staff.

### Expanding child and youth telephone and mobile emergency capability

## Why change is needed

The rate of demand for child and youth mental health services continues to increase. An expanded emergency service for this age group, comprising telephone advice and mobile response is expected to support mental health care and enhance hospital avoidance strategies.

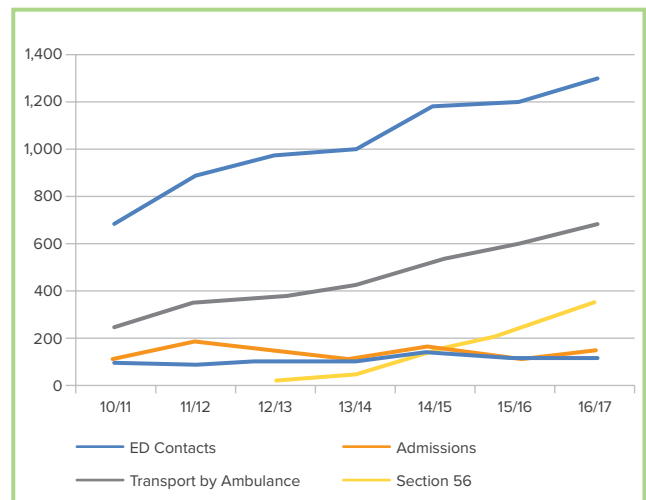


Figure 8: Department for Health and Wellbeing (WCHN) Emergency Mental Health Data (2011-2017)

## What is proposed?

A Child and Youth Telephone Crisis Support service would replace the small existing CAMHS triage service, and run along similar principles to the service described elsewhere in this plan for adults. It would use the “air traffic control” model keeping in contact with the child, young person and/or family until they are effectively engaged in services. The location and operation of this centre would be determined as the larger centre for adults is developed; it may either be a standalone centre, or integrated with the larger support service.

There would also be a 24 hour mobile response to children and young people. This will initially be to Department for Child Protection offices, facilities and accommodation in the short term, and expanded to schools and private residences by the completion of the Plan. This would enable better access to services outside of school and business hours and provide necessary pathways to timely, community-based care and reduce contact with acute hospital based services.

Analysis of existing data suggests that up to 50% of current calls and referrals to CAMHS do not require a tertiary mental health service and can be managed elsewhere in the system through NGO and/or private providers. Initiating a state-wide triage service would enable a consistent response which can also refer some callers to children’s services and Headspace. The service would link with other youth helplines that can escalate matters to the telephone crisis support service when a young person may have a mental illness or be at risk in some way because of that illness.

### How will this be achieved?

Additional staffing and expanding the role of Crisis Telephone support would enable a timely point of entry to child and adolescent services, youth services, and other services which best suits the needs of young people and their families. The expansion of the telephone and mobile services would be implemented using a phased approach.

### Mental health service for children and families in the APY Lands

The Anangu, Pitjantjatjara and Yankunytjatjara (APY) Lands are home to almost 3,000 people, with around 50% of the population being under the age of 25 years (CAMHS, 2018).

Existing CAMHS services have been provided to the APY Lands since 2006 but funding for these services has been short term and cyclical. There are inherent risks to communities and staff in providing mental health services to Aboriginal communities on a short term or temporary basis. The threat of cessation of funding compromises relationships with communities and impacts on engagement and therapeutic outcomes.

### What is proposed?

It is proposed that the current temporarily funded service be established as an ongoing service to the APY Lands communities, supplemented by additional local community staff.

### How will this be achieved?

This service would provide leadership in ensuring stable child and adolescent mental health services to the APY Lands. Increasing the Aboriginal mental health workforce would enable the provision of culturally appropriate mental health care and empowering and building the capacity of the local community.

### What are the measures of success of the combined actions above?

- > Increased access to mental health care for children (and their families) identified as developmentally vulnerable in the Australian Early Development Index (Fifth Plan Domain 1).
- > Proportion of Aboriginal children in SA schools at high risk of clinically significant problems related to behaviour and emotional wellbeing who receive a mental health service.
- > Proportion of children experiencing stable or improved clinical outcomes through the use of National Outcomes and Casemix Collection (NOCC).

- > Improved screening and early intervention for parents and families with mental health needs during the perinatal period, including participation in parenting support programs.
- > Increase in specialist mental health service contacts delivered in the home and/or in an environment that best suits the child and their family's needs.
- > Partnership agreements with key agencies, supporting the embedding of specialist mental health clinicians in other settings.
- > Increased and ongoing access to mental health services for children, young people and their families on the APY lands.

### **Outcome 3: Young people (12-24) have positive mental health and early intervention service access for any emerging mental health issues**

Transition points between services are a point of risk for young people engaging in care and being followed up

#### **Why change is needed?**

Each year, many young people in Australia aged between 16 and 25 years' experience a mental disorder. Statistics indicate that one in seven young people aged 4-17 years will have experienced a mental disorder in the past year (Lawrence et al., 2015). Despite this high incidence, not all young people experiencing a mental disorder will access professional help. This suggests there are barriers around accessibility and design of mental health services for young people.

A recent review on youth mental health services in South Australia (Radovini, 2019 yet to be released) found that the youth model of care for mental health service provision has not been implemented as anticipated, with variable uptake across the LHNs. It highlighted poor and ad hoc transitions between CAMHS, youth and adult mental health services.

#### **Substance use**

The Australian Child and Adolescent Survey of Mental Health and Wellbeing has reported that in 2013–14, 45% of young people with major depressive disorder had also used cannabis or other drugs (Lawrence et al., 2015). The survey also reported that among young people aged 15–24 years:

- > alcohol and illicit drug use were the leading causes of total disease burden in young men
- > alcohol was the leading cause of burden of disease in young women
- > compared to young women, young men experienced nearly three times the disease burden from alcohol use and illicit drug use (AIHW, 2018).

#### **Self-harm**

Self-directed harm is more common among young people, especially young women. Suicide is the leading cause of death amongst young people, with recent data indicating that young people aged 15-24 accounted for 13% of all intentional self-harm (suicide) deaths in 2014-2015 (AIHW 2016).

#### **Young Aboriginal people**

Research has consistently shown that young Aboriginal people are more than twice as likely as non-Aboriginal people to develop emotional and behavioural problems of clinical significance (AIHW 2016).

Higher numbers of Aboriginal people take their own lives at younger ages than non-Indigenous Australians. Young men aged 15-24 accounted for 30% of all male Aboriginal suicide deaths and young women in this age group comprised 35% of female deaths (AIHW & Flinders University 2018).

Western Australian data found more Aboriginal children, 24% (compared to 15% of population), lived in households experiencing seven or more stressful life events in the past 12 months, with those children being more than five times more likely to be at risk for social and emotional wellbeing difficulties (Zubrick 2004).

#### **Young people from culturally and linguistically diverse backgrounds, including young refugees and asylum seekers**

Young people from culturally and linguistically diverse backgrounds may experience increased barriers to accessing and engaging with services due to the potential difference in understandings of mental health and illness and not having access to culturally appropriate support options. Young refugees and asylum seekers may also be at increased risk of severe mental health disorders and suicidal behaviour due to exposure to past traumas, language barriers, loss of culture and family and social networks (Minas et al., 2013).

#### **LGBTQI youth**

Young people from the LGBTQI community can often face discrimination in the form of social exclusion and abuse, significantly compromising their mental health and wellbeing (National LGBTI Health Alliance 2017). It is critical that all youth services provide access to safe care, be supported through training and education with staff, and have access to practitioners with specialist knowledge and skills in supporting young people with diverse needs.

#### **What is proposed?**

Services would be planned for young people aged 12-24, with a common access point for young people in this age group.

The age range of DHW funded youth services would be redefined following further consultation, to be either 16-21, or 16-24. In the defined age category youth teams would be the initial point of contact for young people who require a tertiary mental health service. Youth services would be resourced to provide necessary assessment and treatment services to this age group, and only youth who need a sub-specialist service for a particular condition that cannot be provided in the youth team would be considered for transfer to another service.

The staffing of youth services would be given priority when new positions are created in the future. Staff who are currently providing services to young people in other (adult) teams would be given opportunities to join youth teams, allowing an expansion in the capacity and capability of youth services over time.

The Plan expects that tertiary youth services be governed by the most appropriate service within a geographic region. There is debate about whether youth services are more appropriately managed by adult services or child and adolescent services, noting that South Australia made the decision to allocate youth services to adult mental health services in 2015. In Victoria, the Child and Adolescent Mental Health Service extended its age range to 24 to bring its knowledge and skills in developmental issues for adolescents and young people to this age group.

Currently in South Australia Youth Services are at different stages of development. Rather than commissioning dictating governance, Youth Services will be commissioned for each Local Health Network region based on which service (adult/CAMHS) is best placed to lead. In areas that youth models are either yet to be established (currently one LHN) or remain minimal, both CAMHS and LHNs will have the opportunity to provide the governance of youth services.

### A single access point for youth

- > Many young people have described that accessing mental health support is difficult as there is no clear entry point. If their first contact isn't successful, they may not seek help again. Young people have said they want to access mental health services that are located in youth-friendly settings, co-located with other services including primary health and drug and alcohol.
- > A single point of access to both commonwealth and state funded services for young people would increase young people's access to, and engagement with, services.
- > The provision of a single access point for Youth Services will be part of the Plan, which commits the Government to work with the Primary Health Network (PHN), the operators of Headspace, to develop a joint access point. Such a system is already operated within the Adelaide Primary Health Network, and this would be expanded to tertiary level care with State service collaboration, with similar partnership approaches in Country regions.

### Scope new early intervention partnerships

The Plan proposes new partnerships opportunities with:

- > General Practitioners, PHNs and others to facilitate improved access to health and wellbeing services
- > Youth sector to ensure improved coordination of effort across government using the HiAP collaborative approach with Housing SA, Renewal SA, Families SA, Disability Services SA and SAPOL.

### Schools and higher education sector

Schools can provide an excellent access point for mental health services. There are a range of programs that focus on educating students, teachers and other staff, and families on mental health and wellbeing and building resilience. For example, Be You, which is funded by the Australian Government and delivered by Beyond Blue, Headspace and Early Childhood Australia, aims to promote mental health and wellbeing in early childhood education and care settings and schools (Be You 2018).

During the life of the Plan it is proposed that a component of CAMHS expansion would be committed to work with the Department for Education. Staff embedded in that Department would respond to the needs of students in Government schools, with other staff forming close partnerships with the Catholic and Independent School sector.

### Technology

As more young people can now access technology and the internet, the opportunity for people to access 24/7 online mental health help and support is increasing. In 2016-17, 87% of people aged 15 years and over in Australia were active internet users. Young people aged between 15 and 17 years had the highest proportion of use (98%) (ABS, 2018).

Technology can help young people and their parents access a variety of resources including mental health promotion, screening, prevention, early intervention and referral. Young people can also access information about respectful relationships, violence, bullying, emotional abuse, physical activity, nutrition, sexual health, smoking, alcohol and other drugs. There are ways in which better use of technology could improve timely access to, and engagement with, mental health services for young South Australians.

Technology forms a component of the personalisation agenda of the Plan. Common elements across all age groups include app based models that provide resources to consumers, and communication with clinicians and support workers.



Other elements are web-based health information, internet-based screening, and supportive web-based services via video conferencing (tele psychiatry). As a sub-component of the plan specific technology resources would be available to CAMHS and youth services.

The Plan proposes that current off the shelf apps would be deployed within the short term. A full strategy of technology engagement would be in operation by CAMHS and youth services within the medium term.

### Youth sub-acute residential unit

The aim of a youth sub-acute service is to improve the mental health outcomes for young people aged between 16-24 years who are experiencing early signs of, or recovering from, serious mental illness. This would provide access to youth-friendly, recovery-oriented, psychosocial rehabilitation support. Services would be delivered in a community based residential setting that offers a therapeutic environment that is reflective of least restrictive care.

The youth sub-acute residential unit would sit between hospital based (acute) and community services in a stepped system of care. It would be underpinned by a focus on early intervention and preventing or minimising longer term impacts of mental illness and associated psychosocial disability.

### How will this be achieved?

- > Establish a single point of access for young people to provide an integrated gateway to access youth-friendly services and promote service access through education and other sectors.
- > Develop formal partnerships with other agencies that support better service integration and the delivery of early intervention services.
- > Provide improved services to vulnerable young people through embedding multi-disciplinary mental health services into other community agencies including Education, Youth Justice and Child Protection Services.
- > Commission services across all LHNs that provide consistent access pathways, key transition points, roles and accountabilities and strategies for maintaining continuity of care.
- > Increase timely access to evidence based health information, screening, and supportive web-based video conferencing to complement face to face care.

- > Improve the mental health outcomes for young people who are experiencing early signs of, or recovering from, serious mental illness, through the provision of appropriate recovery-oriented care in a youth-friendly, therapeutic environment.
- > Establish a community based youth sub-acute service for young people aged 16-24 years. It is expected that the Youth sub-acute service will be established in the life of the Plan (subsequent to the commissioning of the adult Crisis Retreat Centre, and the conversion of an existing intermediate care centre).

### What are the measures of success?

- > Increased access to services for all young people (aged 12-24 years) who need a service, and in particular for those from population groups that may be more at risk.
- > Increased access to community-based options for 12-24 year olds.
- > A reduction in suicide deaths for 12-24 year olds, including young people from population groups that may be more at risk – initially amongst those who are receiving a state funded service (by the medium term), but then extending to the entire community through integrated work with other services (such as Headspace) and Suicide Prevention Initiatives.
- > Rates of mental health follow-up after suicide attempt/ self-harm (day 3 and day 7).
- > Proportion of young people recovering from mental illness supported into or resuming employment and/or education.
- > Reduced waiting lists for young people (aged 12-24 years) being connected with a service.

#### **Outcome 4: Aboriginal people have access to culturally safe and appropriate initiatives determined by local communities**

##### **Why change is needed?**

The Australian Burden of Disease Study (AIHW 2016) reports that Aboriginal people experience a burden of disease that is 2.3 times the rate of non-Aboriginal Australians. The authors attribute the gap to many factors including disruption and disconnection from culture, traditions and country, social exclusion, trauma, discrimination, poverty, and higher rates of disease such as diabetes and cardiovascular disease. Broader social determinants such as a lack of adequate access to employment, housing and education play a major role. Poor nutrition and use of tobacco, alcohol, and other drugs are key risk factors that contribute to the gap in health status between Aboriginal and non-Aboriginal Australians.

In recent years, programs designed to improve mental health outcomes for Aboriginal people in South Australia, particularly in rural and remote areas have developed. Indicators suggest that Aboriginal people face higher rates of hospitalisation for severe mental illness, and are less likely to access primary mental health care and receive early help. Anecdotal reports suggest that Aboriginal people are also more likely to access emergency mental health care. Such instances can be associated with emotional crisis, the influence of alcohol and other substances, relationship crises and symptoms of complex grief, loss and trauma (Office of the Chief Psychiatrist 2018).

##### **Suicide**

Reducing suicide and self-harm related behaviour among Aboriginal people is a public health priority for all Australian governments (SCRGSP, 2014). In 2017, the age-standardised suicide rate for Aboriginal people was twice the rate for the non-Aboriginal population (ABS 2018). South Australia has the second highest rate of suicide for Aboriginal people compared with all jurisdictions, with the majority of suicide deaths occurring before the age of 35 years (ABS 2018).

##### **Integrated and culturally appropriate services**

The lack of available, integrated and culturally appropriate mental health services results in many people not accessing and engaging with a service. This can have cascading effects resulting in people presenting late, being diagnosed late and often at a more advanced stage of illness with corresponding physical comorbidities (AIHW 2016).

With the aim of improved mental health and wellbeing, the following key areas need to be considered:

- > Aboriginal leadership development within the mental health system
- > provision of services that address issues of loss, trauma, discrimination, incarceration, violence and substance misuse
- > increased workforce awareness of the impact of cultural issues on the mental health and social and emotional wellbeing of Aboriginal people.
- > improved collaboration and integration at a state, commonwealth and regional level between mental health services, PHNs, NGO service providers, and Aboriginal Community Controlled Health Services
- > initiatives that focus on reducing suicide and self-harm for Aboriginal people receiving mental health care in secure environments.

##### **What is proposed?**

The Plan proposes the establishment of a South Australian Aboriginal Mental Health and Wellbeing Centre (the Centre) to enable all Aboriginal people in South Australia to have their mental health needs met in a more evidence based and culturally appropriate way. This Centre would be collaboratively developed with Aboriginal communities, and will have staff located in metropolitan and rural locations. The Centre would support consumers and clinicians across all services to improve access to quality care for Aboriginal people across the state. It would also offer direct services to individuals and families, and provide a joint clinical support model with local services. The Centre is modelled on the successful Aboriginal Mental Health Service in Western Australia. It would focus on improving access to care and treatment and complementing existing services such as drug and alcohol services, suicide prevention, broader social and emotional wellbeing services and mainstream mental health services.

##### **How will this be achieved?**

- > Development and implementation of a shared care model by offering training, supervision and shared care which will enhance the Centre's ability to 'value-add' to existing services to improve the accessibility, cultural safety and appropriateness of mental health services for Aboriginal people and their families across the state.
- > The Centre will have responsibility for developing effective partnerships for better health of Aboriginal people, partnering and/or co-locating with services in the mental health and social and emotional wellbeing sectors, with the Centre staff based in multiple locations.

- > Developing the Aboriginal workforce and career pathways as well as implementing a student/graduate placement program to encourage new Aboriginal workers in mental health. Aboriginal workers will be supported to undertake training opportunities; to upskill and advance competencies and capabilities.
- > Data collection and reporting for Aboriginal people will be coherent and streamlined. This will ensure evidence based mapping of patterns in the use of health services, identifying gaps and priority areas.
- > Consumer consultation will be central. Aboriginal people will be asked about their cultural background and the information accurately recorded. This will ensure data produced is accurate across jurisdictions. This will align with Actions 13.2, 13.4 and 13.5 from the Fifth Plan.
- > Supporting the development of Key Performance Indicators and research opportunities to evaluate the effectiveness of the Centre's services. There will be a focus on reducing hospital presentations, length of stay, and increasing consumer satisfaction and participation in their mental health care.

### What are the measures of success?

- > Increased access and engagement with services for Aboriginal people with mental health needs through the Aboriginal Mental Health and Wellbeing Centre.
- > A decrease in the number of Aboriginal people in South Australia reporting high or very high psychological distress (NOCC data or other culturally appropriate tools).
- > Proportion of Aboriginal people receiving mental health services experiencing stable or improved clinical outcomes (NOCC data or other culturally appropriate tools).
- > Workforce participation in culturally appropriate training.
- > Culturally appropriate care planning tools used across mental health services.
- > Increase in Aboriginal Mental Health Workforce.

### Outcome 5: Older people have access to mental health programs and support that reduce impacts of mental illness

There are a number of key risk factors which can lead to poor mental health for older adults. These include bereavement and loss, social isolation and poor physical health. Supporting better social connections and community engagement is a crucial response for maintaining mental health and wellbeing (Rickwood, 2005).

The culture of providing care has been called into question following the dehumanising treatment experienced by some of the most vulnerable in our community at the Oakden Older Person Mental Health Service (Groves et al., 2017).

It is estimated that depression can affect 10 to 15 per cent of older Australians whilst 10 per cent can experience distress associated with anxiety disorders. Furthermore, many older people experience complex combinations of ill health, including multiple chronic physical illness and mental illness. Men aged over 85 years have a disproportionately higher death by suicide rate than other age groups (Department of Health 2017). Improving outcomes for older South Australians requires more integrated services, where both physical and mental health care can be provided. Services also need increased skills in recognising the risk factors for suicide.

The older persons mental health plan will provide services that respond to the needs of older people with behavioural and psychological symptoms of dementia (BPSD). These services need to specifically be available to support the care of people with severe BPSD (estimated at 10% of people with dementia) and very severe BPSD (estimated <1% of people with dementia) and to provide the care to those with extreme BPSD (which is rare) (Brodaty et al, 2003).

### Older people from culturally and linguistically diverse (CALD) backgrounds

The Plan recognises that the cultural and linguistic diversity of South Australia's older population is growing. Key priorities for the Plan include improving the diagnosis of both mental and physical health conditions and a greater awareness of symptoms among older people. Achieving this with people for whom English is not their first language adds an important consideration for the design and delivery of mental health care. The role of families and communities is vital in many CALD communities and therefore a more holistic approach is needed.

Commissioned Older Person's Services will be expected to advise and support aged care and community health partners to develop and implement programs that increase mental health literacy in older people from CALD backgrounds and their families, and encourage help seeking.

The routine use of interpreters will be supported by the use of cultural peer workers to be located in areas where there is a concentration of older people of a particular cultural background in the community, or residential aged care facilities have been established to support particular cultural or language groups. Cultural peer workers would have similar training to lived experience workers and would provide support, assistance with identifying goals, and monitoring of mental state in between visits by mental health professionals. This work would initially be trialled with a small number of peers, either based in specialist mental health services or NGOs providing older persons mental health support.

## Veterans

Principal public mental health service for all veterans in South Australia is provided by the Veterans' Mental Health Service located at the Jamie Larcombe Centre (JLC) which is well used by veterans from recent conflicts. Veterans from earlier conflicts and interventions are accessing aged care services and may not use the Jamie Larcombe Centre. Both veterans and older persons mental health services will be commissioned to work collaboratively, so that Jamie Larcombe Veteran's consumers have the support of older persons mental health if experiencing problems of ageing or cognitive decline. Veteran consumers of the Older Persons Mental Health Service will be assessed and treated for post-traumatic stress disorder, and have access to group therapies and peer programs designed specifically to assist older veterans.

### Current mental health and wellbeing services for older people

#### Older Persons Mental Health Service

Older Persons Mental Health Service (OPMHS) in South Australia serves to support older people to maximise their mental health and wellbeing. The main role of the service is to work with the community, aged care and primary health care sectors to prevent or reduce the incidence and impact of mental health issues. OPMHS is designed for people aged 65 years and older and for Aboriginal people aged 50 years and older, who have a diagnosable mental illness or symptoms relating to an underlying issue.

Care can be provided for people experiencing:

- > first onset of a mental illness or disorder
- > dementia which complicates a pre-existing mental illness
- > severe behavioural and psychological symptoms of dementia.

The Plan has adopted the recommendations of the Oakden Report Response Plan Oversight Committee, as described on (page 52) of their final report that provide for sub-acute care, and services for people who experience behavioural and psychological symptoms of dementia.

In parallel the National Mental Health Services Planning Framework highlights the need to increase the number of community older person's workers, as this population has been underserved and is also expanding.

Key themes for the Plan – personalisation, integration and safety and quality will be applied to inpatient and community work, with significant partnerships expected with community and aged care organisations. Where there is potential overlap with Commonwealth funded aged care sector providers the Plan will fund specialist and relevant peer services to provide community visits and residential aged care in reach to assist the aged care sector. This will be resourced through the new initiatives funded by DHW with a new Rapid Access Service to in-reach into the mainstream aged care sector and in-part through the new neuro-behavioural units being established in 2019-20.

It should be noted that people with a psychiatric disability with substantial and ongoing functional impairment who have been eligible for NDIS before the age of 65, should continue to receive that care beyond 65 years of age. Partnership with NDIS providers to older people will become a commissioning and design consideration over the coming years.

#### Why change is needed

An ageing population will see increased need for supported community-based care both in-home and in aged care facilities. Increasing rates of dementia and the challenging behaviours that can arise as a result will require an expansion of intervention and care options.

Appropriate diagnosis of mental and physical health conditions is essential at this life stage, as it can be impacted by a number of factors. Consequently, substance misuse, depression, anxiety, dementia, late-onset schizophrenia, and other conditions can go undetected, untreated or misdiagnosed, with the potential for dire consequences for the person.

## What is proposed?

The Plan seeks to ensure that older people receiving DHW commissioned services have access to programs to enable them to participate fully in their communities and develop and maintain social connectedness. This includes:

- > increased availability, promotion and uptake of mental health programs that support mental health and wellbeing in older people, particularly for those for whom English is a second language
- > an increased focus on suicide prevention for older people
- > the provision of in-reach mental health services and programs to support people experiencing significant distress in residential aged care facilities
- > a stepped model of support for older people with BPSD that is severe, very severe or extreme
- > ensuring that all mental health services are underpinned by a focus on trauma informed care and least-restrictive practice.

## How will this be achieved?

### A Rapid Access Service (RAS) model

The Oakden Response Model of Care Expert Working Group recommended the development of a Rapid Access Service (RAS) model of specialist and responsive in-reach to mainstream residential aged care facilities. This will occur through community OPMHS within the three metropolitan LHNs as well as one to provide services across country South Australia. The service was piloted and modelled by Southern Adelaide Local Health Network OPMHS.

This is an important strategy for addressing future service demands in addition to meeting immediate needs in the interim period while the Neuro-Behavioural Units (NBUs) and Specialist Residential Units (SRUs) services are under development.

The Rapid Access Service will:

- > provide a quality, timely service to consumers and care providers of residential aged care facilities
- > reduce the rate of transfers to hospitals and emergency departments, for consumers with recognised or probable mental illness and/or a diagnosed dementia with complex, severe and persistent behaviours of concern
- > improve the quality of life for residents of residential aged care facilities who have either a recognised or probable mental illness, and/or a diagnosed dementia with complex, severe and persistent behaviours of concern
- > streamline care pathways between residential aged care facilities, mental health services and other key agencies

- > build skills in managing psychiatric illness and dementia with complex, severe and persistent behaviours of concern via education and training for staff in residential aged care facilities
- > RAS expansion will occur within the short to medium term of the Plan.

### Neuro-behavioural unit for people with extreme BPSD

The Brodaty Tiered model for BPSD (Brodaty, Draper & Low, 2003) predicts the prevalence of severe, persistent and challenging behaviours that define Tier 7, suggesting that South Australia currently has 26 people who fit the Tier 7 criteria, with this predicted to rise to 34 people by 2026.

A high number of people in Tier 7 are men aged in their late 60s or 70s who have displayed violent behaviour that has harmed other residents or staff. The dementia these men experience is often alcohol-related, frontal/temporal or vascular dementia. Tier 7 consumers have often proven very challenging to manage safely in a hospital or special nursing home environment.

It is proposed that two Neurobehavioral Units (NBU) with a total of 24 places to be available across two locations. These services will provide care for all people with very severe to extreme BPSD, including those with younger onset dementia.

The NBU will be operated as a high dependency unit for high acuity presentations, but will also be developed as a home-like environment, enabling therapeutic and least restrictive care. The units will focus on working in partnership with the consumers and their families, ensuring the needs of the individual are valued and supported.

## Measures of success

- > Increased access to holistic mental health care for older people in residential aged care facilities, including clinical and psychosocial support delivered by state mental health services.
- > A decrease in the proportion of older people in South Australia reporting high or very high psychological distress, people with diverse cultural and language needs (NOCC data).
- > Increased proportion of people with complex BPSD receiving care in appropriate care facilities.
- > Proportion of people receiving older persons services who report their individual needs and values were respected and incorporated in their care (YES survey).
- > Proportion of people receiving older persons services reporting they had opportunities for family and carers to be involved in their care if they wanted (YES survey).



- > Evidence of an improvement in people’s participation in daily activities in their chosen community using the National Outcomes and Casemix Collection (NOCC).
- > Assessing and measuring effective care and support from carers perspectives using the Carer Experience of Service (CES) survey.

## 5.3 Integrated Care

### Outcome 6: People obtain timely and effective mental health care and support that promotes wellbeing and respects diversity

This outcome covers:

- > Improved Crisis Care Pathways
  - Embedding mental health clinicians with SA Ambulance and SA Police
  - Crisis response partnerships with first responders
  - Urgent Mental Health Care Centre
  - Safe Haven Café
  - Mental Health Crisis Support Telephone and Mobile Teams
  - Drug and Alcohol Co-morbidity
- > Building capacity through the NGO services sector
- > Hospital in the Home type programs
- > Future Crisis Retreat Centres
- > Technology that enhances care outcomes.

#### Improved Crisis Care Pathways

#### Why change is needed?

Over the last decade in South Australia, mental health acute bed numbers have consistently sat above the national average. However, it remains unclear whether this has generated an improvement in outcomes for people with mental illness in South Australia. Even with our community based programs, people in distress frequently present to emergency departments for assistance and support.

Presentations	Mental Health	Drug & Alcohol	Rest of Health	Grand Total
Presentations	15,601	5,192	346,211	367,004
% Presentations	4.3%	1.4%	94.3%	100.0%
Visit Hours	9.6	7.8	4.8	5.0

Figure 9: Summary of presentations to the emergency department for mental health, drug and alcohol and the rest of health, as well as average visit time 2017/2018.

During the development of the Plan, there was strong support to broaden the focus of measuring outcomes that go beyond the occasions of care and length of stay, and to increase the focus on outcomes from consumers’ perspectives.

*“Often I can’t get in to see, or afford the gap payment at my GP, or make an appointment with my community mental health worker when I need to – I don’t want to have to tell my whole story yet again to someone else. I know when I need to get help and if there’s no alternative I have nowhere else to go except for the ED!*

*I feel I’m part of the problem (of ramping ambulances and overwhelmed EDs)...and it makes it worse – for me... and the staff.”*

*(MHSP Community Forum, February 2018)*

#### How will this be achieved?

#### Embedding mental health clinicians with Ambulance and Police (SAPOL)

Mental health workers would be embedded into Ambulance Services to provide a combined mental health and ambulance response, 24 hours per day, seven days per week. This will be an initial step in the plan that in some areas would also embed staff with police. Ultimately there would be three mobile mental health teams. The service will link to intensive home based support peer workers. Should the recipient agencies not wish to have staff embedded in these settings, these staff would still be required to provide a mobile crisis response service.

In SAPOL a mental health staff member will be made available in their communications centre to advise and support the police response to emergencies involving people who are experiencing a relapse of mental illness.



### **Urgent Mental Health Care Centre**

As described on page 18, an Urgent Mental Health Care Centre would be established in the central business district, with the expectation that further centres can be developed. These units would be staffed by clinicians and peer workers, and enable people to self-present in a crisis. They would also accept ambulance referrals up to triage level 3 (urgent) and police referrals.

Urgent Mental Health Care Centres could:

- > provide 12 hour cover initially, with a future increase to 24 hour coverage
- > deliver emergency assessments and crisis therapy interventions, and arrange follow-up
- > facilitate direct referrals to community teams, NGO support and crisis accommodation and direct admissions if there is a vacant bed in region
- > decrease numbers of mental health self-presenters to emergency departments
- > accept SAAS and SAPOL referrals (up to Triage Category 3).

### **Crisis call (referral and monitoring) centres and mobile teams**

As described on page 18 existing 24 hour Mental Health Triage Service would be bolstered to become a Comprehensive Mental Health Crisis Support Telephone and web-based service.

It would use the 'air traffic controller' concept where a call taker tracks and continues to have responsibility for a caller's service provision until they are connected with a face to face service. It will coordinate care responses using the latest real time technology to provide telephone support to callers and coordinate mobile teams.

### **Drug and alcohol co-morbidity**

The Plan supports a greater focus on maximising current resources and capacity through improved partnerships with Drug and Alcohol Services of South Australia (DASSA). This would include (i) commissioning of emergency mental health services that supports the allocation of resources to an Acute Behavioural Assessment Unit. This would be developed in a major hospital in partnership with DASSA and local emergency department toxicology services; (ii) the expansion of co-morbidity services with DASSA clinicians embedded into mainstream mental health services.

The latter initiative would have a relapse prevention role in situations where people with a mental illness relapse due to substance use.

### **Safe Haven Café**

An example of an alternative care option to emergency departments is the 'Safe Haven' café established in Aldershot, Hampshire, UK, in 2014 (Wessex Academic Health Science Network 2019; Whitfield, 2015). The café operates as an evening drop-in service, where people can present if they are experiencing a mental health crisis to receive support and, if needed, assessment. An evaluation found that the number of admissions to acute inpatient psychiatric beds decreased by 33% from within the 'Safe Haven' catchment area (NHS, 2016).

In Australia in 2018, St Vincent's Hospital Melbourne established a Safe Haven Café based on the UK model with similar results. The model used by St Vincent's Hospital also emphasises provision of a safe, supportive and therapeutic environment for people who are experiencing a mental health crisis and are in need of assistance, but not necessarily acute care (St Vincent's Melbourne 2018).

The Plan proposes development of a Safe Haven Café in the Central Business District as a hospital avoidance initiative. In accordance with other models the Café will have peer worker and mental health workers on site. It is planned that the proposed café will be accessible in the evenings and for a longer period on weekends.

### **Building capacity through the NGO services sector**

The NGO community mental health sector is a major provider of mental health services.

NGO services would be commissioned to provide:

- > crisis intervention services extending current intensive home based services;
- > comprehensive crisis services that provide both traditional NGO support services and clinical services as well; and
- > services that support new initiatives such as Urgent Mental Health Care centres, and mobile teams.

### **Hospital in the home type programs**

Additional areas of consideration include mental health hospital in the home services with direct links to mental health clinicians, the emergency department and adult community mental health teams. It is important to note in these types of service models that service provision is not hospital avoidance per se, but hospital substitution with clinical governance remaining with the relevant hospital and admissions funded through case mix payments.

The Plan will support commissioning through Wellbeing SA that allows LHNs to use bed based funding sources for effective hospital substitution services.

### Future Crisis Centres

The Plan gives consideration to a Crisis Retreat Centre being established with 60 crisis retreat beds operating statewide by the completion of the Plan. The centre would provide a specialised alternative to emergency department presentations of people with higher acuity mental illness/ suicidal ideation.

- > Function as an integral part of a regional crisis system serving a whole population.
- > Operate in a less clinical and more 'home-like' environment.
- > Utilise peer workers as integral staff members.
- > Have 24/7 access to psychiatrists and mental health professionals with advanced skills.

### Technology that enhances care outcomes

#### Why change is needed?

Effective digital technology has the potential to transform outcomes and experiences for health providers and consumers as they have great potential to improve accessibility, quality, safety and efficiency of mental health care.

The ability to utilise high-quality data that has a commonly understood meaning is essential in delivering a recovery orientated service, through mechanisms that provide openness and engagement with clinicians, consumers and care providers.

A final report published by Mental Health Australia and KPMG: Investing to Save (KPMG & MHA 2018), reported that e-mental health programs have been found to be effective for mild to moderate mental illnesses and that they should be incorporated into, and considered part of, mainstream services, rather than an adjunct intervention. The report states e-mental health interventions are able to deliver components of psychological therapies through teleconference/telephone, video conference and/or internet-based apps and can do so without a one-to-one relationship with a clinician.

#### How will this be achieved?

- > Clinicians and consumers are supported to learn how to maximise the benefits of digital health tools, including mobile applications.
- > Rebuild the interface of the Community Based Information System (CBIS) used by most state public mental health providers to make it more user friendly, and efficient. The current electronic record systems are time consuming and reduce direct support and care for the consumer.
- > Create a mobile interface so that mobile clinicians can readily access data and upload clinical notes without returning to the office.
- > Redevelop the current mental health care plan to enable all elements of health, recovery, therapy, human rights and socio factors to be incorporated into easily shared documents that are understood by staff, consumers and carers.
- > The Plan proposes that current off the shelf apps would be deployed in the short term. A full strategy of technology engagement would be in operation within the medium term.

To ensure that these initiatives can be achieved to improve care outcomes, it is proposed to develop a Mental Health Information Technology Plan within 18 months that will be supported by a robust business case, timeframes for implementation and consideration of funding it in a climate of competing priorities.

#### Rural Considerations

Compared to people living in urban areas, individuals in rural and remote communities are often exposed to an increased number of risk factors for mental ill health, such as economic problems, high unemployment, high suicide rates, increased domestic violence (AIHW, 2018), and poor physical health. Telehealth to rural and remote areas will be supported as part of the Plan.

#### Measures of success:

- > Reduced waiting times for access to services (due to an improved crisis system – urgent mental health care, mobile response and crisis retreats). Key success measures will be a reduction of extreme waits in EDs within the short term, national average waits in ED within the medium term (this has not been achieved for many years), and national and international best practice performance by the completion of the Plan.
- > Reduction in hospital admissions and readmissions through access to alternative service options.

- > Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs (YES survey).
- > Proportion of people receiving services who report their individual needs and values were respected and incorporated in their care, including family and carer involvement where appropriate (YES survey).
- > A decrease in the number of people reporting very high levels of psychological distress (NOCC data).
- > Rate and duration of post-discharge follow-up from inpatient and community mental health services .
- > Partnerships with multicultural services and an increase in engagement with interpreters .
- > Assessing and measuring effective care and support from carers perspectives, where appropriate (CES survey).
- > Access to telehealth and face to face assessments and therapy for people living in rural and remote areas.

## **Outcome 7: Services work together in partnership to provide a coordinated response to meet people's individual needs**

### **7.1 Information is shared when and where it is needed to support the best care**

#### **Why change is needed?**

The sharing of a person's information between organisations providing a service is legislated nationally by the *Privacy Act 1988* and its associated principles. At a state level, information sharing between services involved in a person's care and support is guided by the Information Sharing Guidelines and the guiding principles in the *Mental Health Act 2009*.

While the legislation and guidelines are supposed to assist as a guide for the sharing of information, they are often perceived as a barrier that prevents information sharing. In some cases this has led to consumers not receiving the best care and support due to a lack of knowledge that one service provider has about another service provider. This has also sometimes resulted in carers being excluded from receiving information due the lack of understanding of what can and cannot be shared.

#### **What is proposed?**

Information sharing is seen by service providers as a way to enhance a consumer's care and not hinder it. This will be achieved when:

- > there is appropriate governance in place where key partners can regularly collaborate with defined roles and responsibilities to facilitate effective information sharing that benefits consumers and the community
- > privacy obligations are upheld.

#### **How will this be achieved?**

- > Information sharing guidelines clarify how mental health information is shared in the context of applicable laws. A decision tree based on existing models will provide simple and practical guidance to staff. A communication and implementation strategy will support practice.
- > Information is shared and minimum service level data is captured, along with data such as housing, employment, training, and meaningful activity that link to social determinants of health. This information will be individually used to support personal care planning, and across the service used to support service integration.

## 7.2 Pathways to transition into and out of care that is coordinated across services to streamline the consumer experience

### Why change is needed?

Access to services isn't always timely. People in country South Australia may have to wait for long periods of time in their local emergency department, to gain access to a metropolitan emergency department. In some instances there are high levels of distress as some services are not available after hours or at weekends.

There are often specific criteria that are required to be met to access services, which may be based on the severity of a person's condition. This requirement means the system may miss opportunities to intervene early because people need to reach a crisis before they can access services

Overall, partnerships can be agreed at strategic level but not enacted at local level because staff are busy, and people change positions. Funding doesn't flow across services and organisations are hesitant to share risk. The Fifth Plan commits all governments and all service agencies such as PHNs and LHNs to work together to achieve integration in planning and service delivery at regional levels to improve mental and physical health outcomes for people with lived experience of mental illness. Follow up following discharge and transition periods between services can be difficult in circumstances of unstable housing and homelessness.

### What is proposed?

A continuous and supportive pathway across the consumer journey in and out of care, stepped up and down as needed with comprehensive options offered by a range of partners working together. The factors contributing to success include:

- > integrated services with common entry points, where tertiary services are available to support consumers and carers access primary care, and where people can be linked directly to the most appropriate level of care based on early and skilled triage
- > assessments are undertaken in Urgent Mental Health Care Centres (see Outcome 6) or by mobile community team rather than in the emergency department
- > comprehensive assessments are undertaken that in addition to individual assessment and treatment, identify social, family, and community needs
- > appropriate care is given at the appropriate time and this forms the basis for decision making with consumers about discharge planning
- > shared care arrangements are encouraged with primary care and private practitioners

- > discharge planning is discussed with consumers and their loved ones from day one and the NGO sector and GPs are part of the discharge planning conversation
- > service continuity of care can be re-established easily when consumers transfer between services, without having to meet eligibility criteria each time – with people's access being placed 'on hold' not 'ceased'
- > assertive follow up is available in all mental health services with protocols/procedures developed to prevent people falling through gaps in care. This includes home-based supports led by NGOs
- > integrated planning in commissioning and designing services is undertaken involving all partners in care and support.

### How will this be achieved?

- > Partnership agreements will identify the key partners; define the roles and responsibilities of partners and the shared vision and values for working together.
- > DHW's commissioning of services will take into account PHN commissioned services to reduce duplication, address gaps and incorporate a requirement for mutual support, to give PHN services access to state tertiary services for opinion and advice.
- > Care coordinators can gather information, assess and present options, advocate for access and coordinate services across multiple providers. These coordination roles can be filled by peer workers.
- > A youth common entry point to be established within the medium term (subject to work with partners) and if successful extended to adult services by the completion of the Plan.
- > A new entry point for state funded NGOs will be established within the medium term, which will not require prior referral to a mental health service clinical team.
- > Allowing additional referral points to NGO sector psychosocial programs will facilitate timely access to appropriate services and support.
- > Home-based supports managed by the NGO sector will be available for people not eligible for a NDIS service. A pre-qualified provider list of NGOs will be established, and organisations on this list will become partners in co-design and service model development.
- > Clinical Pathways will be established in rural and remote settings to deliver similar service types through local services and outcomes to metropolitan services.

During 2019-20 and 2020-21, new service models will be developed for the provision of NGO services with our service partners to support mental health consumers to stay well in the community. The new service models, which would replace the current models that have been in place for some time, could be provided from either state based mental health services or from the private sector (such as General Practitioners).

Mental Health consumers currently have a number of service entry points to seek services from either state based services, through Primary Health Networks and General Practitioners. DHW will work with its service partners to develop a more integrated referral system and entry criteria for these range of services. Detailed discussions will occur with all partners and stakeholders to agree on service entry points and service criteria.

The services will be tendered with existing funding to be redistributed across the new service models.

**Specialist drug and alcohol services and specialist mental health services work together to each contribute their own expertise and experience when providing care and support**

**Why change is needed?**

People experiencing co-existing alcohol and other drug issues and mental health issues are not always seen by mental health services. There can be resistance among workers to deal with alcohol and other drug issues in mental health services. The range of assessment tools and processes is variable. In many instances, the interrelated nature of alcohol and other drug issues, mental health and associated behaviours is complex. A common complaint from staff is that dealing with people who are experiencing mental illness in combination with alcohol or other drugs and are exhibiting aggression and violence is an extremely challenging part of their work.

**What is proposed?**

The experience of each sector is combined to leverage strengths of each in the following ways:

- > mental health staff will be trained and supported to deliver a “primary” or “secondary” level drug and alcohol services to people with dual diagnosis (people who experience both a mental illness and substance use disorder). That is to undertake an assessment, and provide at least first level interventions – advice about harmful use, motivational interviewing, or CBT applied to Drug and Alcohol disorder.

- > mental health staff in turn will be assisted by DASSA drug and alcohol staff who will be embedded into the mental health services of each local health network, to provide a “tertiary” specialist service – consultation and advice to mental health staff, and direct co-management of people who have not responded to first level interventions by drug and alcohol staff
- > conversely Mental health services will assist drug and alcohol services when asked for help in responding to consumers of drug and alcohol services who are experiencing a mental health crisis
- > greater involvement by mental health services to integrate advice and support from clinicians with expertise in addiction and co-morbidity into care planning
- > co-assessment should occur between drug and alcohol services
- > mental health workers will be available for people with complex needs.

**How will we this be achieved?**

- > Substance use should be part of assessment for every mental health intake then further assessment if screening indicates risk with an appropriate follow up plan.
- > Mental health comorbidity workers are engaged to build capacity within mental health teams. Workers contribute to and deliver training in counselling responses i.e. brief intervention, relapse prevention.

**The transition to the National Disability Insurance Scheme is managed and people are supported so that no one is worse off**

**Why change is needed?**

*Impact of the National Disability Insurance Scheme on NGO mental health service providers*

The National Disability Insurance Scheme (NDIS) represents a significant change in the way people with disability including people with psychosocial disability access supports, empowering them to exercise choice and control. In that regard, it constitutes a profound change from the prior welfare approach, which was typically block funded. This new approach has posed challenges not just for the National Disability Insurance Agency (NDIA), but also for providers and participants as they adapt to a new way of interacting. Key roles for state NGO providers are described on page 16.

### *Impact of NDIS on people with a mental illness and their families*

Under the NDIS, people who can demonstrate that they have a psychosocial disability resulting from a mental health condition will be offered support if they have a substantial functional impairment which impacts day to day life. Areas that they may experience functional impairment include learning, mobility, communication, social interaction, and self-care or self-management, and it has been assessed that their impairment is likely to remain across their lifetime. It is not the case that everyone who has a mental illness will have a psychosocial disability, however, for those who do, psychosocial disabilities can be severe, long-lasting and can have ongoing implications for their recovery.

It is also important to identify the non-clinical rehabilitation and support needs of South Australians with a severe mental health condition who are deemed ineligible to receive NDIS funding, and work to ensure continuity of service for them. These services are, in general, delivered by NGO run community managed mental health services. These services include individual rehabilitation support, supported housing, day and group, mutual self-help and carer respite and support programs.

### **What is proposed?**

Work will be overseen through the *SA National Disability Insurance Scheme Psychosocial Disability Transition Taskforce* and implementation group.

### **How will this be achieved?**

- > Work with key stakeholders including non-government organisations to identify and support those consumers ineligible for NDIS and ensure continuity of services are available to them if needed.
- > Strong collaboration and partnerships with the NDIA are needed at all levels and sectors to ensure no mental health consumer who needs support and services misses out.
- > A direct NGO intake mechanism will be developed, and funded NGOs will deliver crisis support, psychosocial rehabilitation, and case coordination. These services will be complementary to the NDIA and meet the needs of consumers and carers who have a significant need but are NDIA ineligible.

### **Mental health consumers have timely access to safe, secure and appropriate housing**

#### **Why change is needed?**

Research suggests that approximately 30-40% of the homeless population in urban areas live with a severe mental illness. The social disability associated with severe mental illness can impact one's ability to source and maintain housing, and given that homelessness has an impact on physical and mental health, safe, secure and permanent housing can be the base required for people to achieve goals in relation to their recovery and improve their quality of life.

There is an acute need across South Australia for more affordable, longer term housing, and a larger variety of accommodation types, including in rural and remote areas of the state. Insufficient affordable housing is leaving people vulnerable, sometimes forcing them into inappropriate short-term accommodation, couch surfing or homelessness which further compromises their mental health and wellbeing.

The need for more affordable housing options is becoming more imperative with the introduction of NDIS, both for mental health consumers who are NDIS eligible and for those with a psychosocial disability who are not eligible. Consumers with a disability are rightfully seeking more choice and control over how they live and where they live.

People with mental illness regularly experience isolation, discrimination, and stigma (WHO, 2016), and as a result find it difficult to secure and maintain appropriate and affordable housing.

#### **What is proposed?**

Due to the current reduced affordability, accessibility and variety of stable supported accommodation across the state, plus the increasing demand being generated by the introduction of NDIS which enables more choice and control to mental health consumers as to where and how they live, there is an increasing need for mental health services to strengthen formal partnerships and plans with Housing SA, community housing providers, and mental health NGOs to ensure that adequate housing supply can meet demand into the future.



## How will this be achieved?

- > Existing agreements with housing providers will be renewed. Mental Health Services will not be a housing provider, but will work to ensure that clients have support to maintain their tenancy, and if homeless receive mental health care as part of a housing first model.
- > Safe, secure and appropriate housing is an important social determinant of good mental health and wellbeing and should be part of integrated models of service delivery for mental health consumers.
- > Mental health services will be commissioned to support a Housing First model, that seeks to provide stable accommodation to people who experience a psychosocial disability with necessary levels of psychosocial support and clinical services.

## Measures of success for this outcome:

- > increased access to mental health services (service contacts) for people in other settings
- > increased rates of follow-up within 7 days of discharge from mental health services
- > increased number of people on discharge from services who are transitioned into accommodation that is safe and aligned with their recovery goals
- > proportion of registered people recovering/recovered from mental illness who experience stable or improved clinical outcomes, including population groups who are more at risk
- > proportion of people recovering from mental illness supported into or resuming employment or education
- > enhanced partnership arrangements with other services, including clear referral pathways
- > number of care plans developed in partnership with the consumer, their family/carer and other services where appropriate (YES survey)
- > proportion of consumers actively connected with other services including GPs, general health, employment or education, accommodation, and other services
- > assessing and measuring effective care and support from carers perspectives, where appropriate (CES survey).

## Outcome 8: People with a mental illness will have better physical health and live longer

### Why change is needed?

For individuals with severe mental illness, accessing comprehensive health services that provide health promotion, screening and treatment for physical, as well as mental health conditions can be difficult. People living with mental illness often have poorer physical health than other Australians, with physical health needs often being overshadowed by the person's mental health issue. Possibly due to lack of early detection and intervention; 'too little, too late', mortality rates are significantly higher in this group, for example, males experience a 40% higher rate and females experience a 20% higher rate (Lawn 2012).

The National Mental Health Commission (2016) describes that compared with the general population, people living with mental illness are:

- > twice as likely to have cardiovascular disease
- > twice as likely to have respiratory disease
- > twice as likely to have diabetes
- > twice as likely to have metabolic syndrome
- > twice as likely to have osteoporosis
- > 50 per cent more likely to have cancer
- > 65 per cent more likely to smoke
- > six times more likely to have poor dental health.

The WHO guidelines recommend the following individual health interventions, health-systems adjustments and actions that can be taken at the community level:

- > at the individual level, risk factors for poor physical health (e.g. smoking, an unhealthy diet or lack of regular exercise) and physical health conditions need to be identified and treated
- > at the health system level, mental health clinicians need to be better able to address physical health conditions, and physical health clinicians need to be better able to address the needs of people with severe mental disorders
- > in the wider social context, strategies that involve the wider community, including peer and family support as well as community stigma reduction strategies, should be considered (WHO, 2018).

Physical health comorbidity for people with a mental illness has become so widespread that some experts suggest that mental illness be officially recognised as an independent risk factor for diabetes (Dursun et al., 2005).

Metabolic syndrome has become highly prevalent and is the expectation, rather than the exception for individuals with long-term mental disorders such as schizophrenia (De Hert et al., 2009). The prevalence of comorbidity is particularly concerning given that many individuals will have more than one of these health problems. Given the extent and concerning nature of comorbid physical health conditions among those with mental illness, it is crucial to improve how our mental health system and community responds to this major concern (Lawn, 2012).

Mental Health services will also support consumers, carers and service providers in general health services, noting the significant co-morbidity that can exist with physical illness and the need to deliver holistic care.

### **Aboriginal and other culturally and linguistically diverse people**

There is an increased risk of physical illness and mental illness among Aboriginal peoples, and other CALD communities (AIHW 2018; AIHW 2014). However, few descriptive epidemiology studies or reviews on prevalence of co-occurring serious mental illness and physical illness exist. Research regarding the ability of health services to address comorbidity and the availability of integrated-care intervention options is also limited. Additional research is needed to address these gaps and government funding to this research area is critical (Happell et al., 2015).

### **What is proposed?**

- > Integrated care planning and delivery which recognises and addresses consumers' broader health needs.
- > Strong partnerships are promoted in coordinating services around the health and mental health needs and preferences of individuals through integrated care with GPs.
- > Population groups who may be considered more at risk will have access to better integrated services to address their mental health and health needs.

### **How will this be achieved?**

- > Systems and processes in place to collect and report on general health needs for people accessing mental health services.
- > Improved integration and referral pathways between mental health services and general health service providers and participation by mental health services in integrated one stop services for at risk people that provide physical and mental health. This includes within mental health services the provision of physical assessments, and metabolic clinics, and partnership arrangements where mental health services are delivered in conjunction with physical health services for at risk communities – including homeless people.
- > Improved physical health protocols and guidelines regarding screening for and monitoring a wide spectrum of mental illnesses while maintaining a whole-of person approach, consistent with the WHO Mental Health Action Plan (2013).
- > Cardio metabolic monitoring of consumers taking antipsychotic medication paired with or followed by evidence-based therapeutic interventions .
- > Our workforce using digital health technologies with confidence to provide a healthcare service to monitor physical as well as mental health symptoms. An integrated health promotion program will be delivered to clients of mental health by Wellbeing SA that supports both mental and physical wellbeing.

### **Measures of success:**

- > Proportion of people receiving mental health services who are actively engaged with a GP and other health services based on their individual needs, including cardiovascular (CVD) screening, dental care, optical care, diabetes care.
- > Proportion of people receiving mental health services who have access to allied health care, including exercise physiology, dietetics, podiatry, physiotherapy, occupational therapy, audiology, clinical and health psychology.
- > Decreased prevalence of chronic health conditions for people accessing mental health services.
- > The collection of general health information included in routine assessments, care planning and clinical reviews.
- > Enhanced partnership arrangements with other health services, including clear referral pathways and collaborative care planning.

## 5.4 Safe and High Quality Care

### Outcome 9: Improving safety and quality in mental health services to reduce harm, uphold human rights, and support inclusion

#### Why change is needed?

Improving consumer safety must embrace treating consumers and families with dignity and respect. Further, the provision of high quality care in the right environments, creating systems that prevent both error and harm and creating a workforce culture can be supported by clinical practice improvement and the reliable implementation of models of care supported by training.

#### Towards Zero Suicide in mental health services

Many South Australians have been impacted in some way by the death of a person who has died by suicide. Suicide is the leading cause of death for Australians aged 15 to 44 years (SA Health, 2017).

#### What is proposed?

##### Towards Zero Suicide Strategy

Towards Zero Suicide is a commitment to prevent suicide in health and behavioural health care systems. It also encompasses a specific set of tools and strategies and therefore is considered a concept as well as a practice. The main proposition for Towards Zero Suicide is that suicide deaths for people under care are preventable, and that a 'Towards Zero Suicide' approach is an aspiration to improve care and outcomes for people at risk (Labouliere, 2018).

By increasing cooperation and striving for continual improvement, our services can avoid a blame culture and redefine mistakes as opportunities for improvement that help to create a just culture and enables Towards Zero Suicide.

A Towards Zero Suicide Clinical Practice Improvement (CPI) strategy will be developed associated with a training program incorporating quality improvement skills. The program will provide theory and practical skills translatable into the workplace to improve care. Participants undertake a work place clinical practice improvement project as part of the program. The course content includes:

- > understanding how to organise a whole of system approach to quality and safety throughout all levels of the health service
- > theory of improvement science
- > theory of reliability and human factors

- > skills development in the use of quality improvement diagnostic tools, and use 'plan do study act' cycles
- > skills development in measurement for improvement, consumer engagement, change management, spread and sustainability of change.

People identified by mental health services as at risk of suicide and/or self-harm will be actively supported by mental health services.

#### How will this be achieved?

- > Pivotal to the sustainability of Towards Zero Suicide CPI is the establishment of a Towards Zero Suicide Clinical Practice Improvement Initiative that will support front line clinician and local consumers and carers in initiatives to prevent suicide. The service initiative is planned for five years, to be developed jointly by the Office of the Chief Psychiatrist and then transferred to the Commission on Excellence and Innovation when it is established.

#### Inspections Framework – a collaborative approach

The *Mental Health Act 2009* establishes the position of Chief Psychiatrist and provides the position with a number of powers and functions, including the power to conduct inspections of incorporated public hospitals and licensed private hospitals. Inspections provide the Chief Psychiatrist with an essential mechanism to carry out their functions, such as monitoring:

- > the standard of mental health care
- > the treatment of consumers
- > the use of restrictive practices
- > the administration of the *Mental Health Act 2009*.

Inspections also supply the Chief Psychiatrist with data that will inform other functions, such as promoting the continuous improvement of mental health service delivery and organisation, and advising the Minister on issues relating to mental health.

#### Why change is needed?

- > A safe health system either reduces or avoids potential or actual harm to consumers.
- > Quality improvements that reflect consumer and community expectations, with local reforms guided by state-wide plans.

## What is proposed?

The Chief Psychiatrist Inspection Protocol describes how inspections are conducted, the criteria they use, and the reporting and recommendation processes in place. The Protocol applies to incorporated public hospitals, licensed private hospitals and all facilities determined by the Chief Psychiatrist to be an Approved Treatment Centre, a Limited Treatment Centre or an Authorised Community Mental Health Facility.

## How will this be achieved?

- > Inspections to be carried out with reports and recommendations forwarded to the relevant incorporated public hospital or licensed private hospital from the Office of the Chief Psychiatrist.
- > A pool of lived experience consumers and carers will be engaged to participate in inspection teams.

### Reducing the use of restraint and seclusion in mental health services

Restraint and seclusion are considered the more extreme end of the restrictive practice spectrum, which can also include the use of mental health legal orders, exclusion, coercion and limit setting to restrain a person's behaviour,

There is no evidence to support the use of restrictive practices as therapeutic interventions

There has been international consensus on the use of Huckshorn's 6 Core Strategies, developed in 2006 at the National Association of State Mental Health Program Directors as a process to reduce the use of restraint and seclusion. An evaluation conducted by Wolfaardt (2013) concluded that *'the six core strategy intervention with sensory modulation assisted staff to moderate challenging behaviour [and] as a result seclusion practices were nearly omitted and the trend in restraint data suggested a reduction in the use of restraint as well.'*

These six strategies are:

1. Leaderships towards organisational change;
2. Use of data to inform practice;
3. Workforce development;
4. Use of seclusion and restraint prevention tools;
5. Consumer roles in inpatients settings; and
6. Debriefing techniques.

More recently, Te Pou in New Zealand (2014) released the 'Towards restraint free mental health practice' paper that expounds the continued relevance on the use of the 6 core strategies while adding in more explicit information on trauma informed care, recovery oriented strategies, person-centred care and sensory modulation processes.

Reducing and where possible eliminating the use of all and any restrictive practices is a state and national priority (Fifth Plan, Priority 7) and this starts with respectful, trauma informed practice that has the person at the centre of all decision making related to their care.

With recent increases in SA on the rate of seclusion, it is imperative that a renewed focus on eliminating restrictive practice where ever possible be implemented across all mental health services. Preventing behavioural episodes occurring, and avoiding restraint, will also make safer workplaces for staff.

## Why change is needed?

To reduce the incidence of restrictive practice, limiting traumatisation and promoting a person centred, recovery orientated mental health service.

## What is proposed?

Trauma informed and recovery oriented care is incorporated into mental health service practice and policy, and a new Restrictive Practice Policy is implemented.

## How will this be achieved?

- > Complete a review of restrictive practices in line with the recommendations from the Independent Commissioner Against Corruption Oakden Inquiry (Lander, 2018), and implement a new policy in the first 18 months of the plan.
- > Assist in the development of the Safewards program in all mental health inpatient services.
- > Monitor the delivery of trauma informed care training across mental health services.

### Sexual Safety in Mental Health Services

The *Mental Health Act 2009* ensures 'that persons with severe mental illness receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with the goal of bringing about their recovery as far as is possible; and retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of the services'.

## Why change is needed?

Ensuring people's safety, including sexual safety, when accessing mental health services is fundamental. A strong values structure and cultural sensitivity that is evident in the practice of all mental health care providers.

## What is proposed?

A Sexual Safety in Mental Health Services Policy Guideline and Policy Directive will inform commissioning by DHW, and service design and delivery by local health networks and funded services.

## How will this be achieved?

- > Policy Directive and Guideline be promulgated, so that commissioning of clinical services will provide for gender safety through strategies such as single sex wings of wards, and single sex lounges

## What are the measures of success?

- > Evidence of Clinical Practice Improvement projects focusing on Towards Zero Suicide being facilitated and implemented in services, Connecting with People and Trauma Informed Care training delivered to staff, with evidence of approaches seen in clinical practice and documentation.
- > A reduction in the number of suicides for people receiving mental health care and treatment (DHW commissioned services) that commences within the medium term and is sustained at the completion of the Plan.
- > Chief Psychiatrist inspections completed.
- > A reduction in the incidence of any form of restraint/seclusion/exclusion.
- > Mental health services meet the targets set out in the National Safety and Quality Health Service Standards (ACSQHC, 2017).
- > A reduction in the number of incidents in mental health services, measured through the use of the Safety and Learning System.
- > Assessing and measuring effective care and support from carers perspectives, where appropriate (CES) survey.
- > Relevant National standards will be maintained across all domains of safety and quality: National Safety and Quality in Healthcare Standards with mental health additions are fully implemented in all funded LHN services, and the National Standards for Mental Health Services are met by all funded NGO providers.

## Outcome 10: Mental health services promote fairness, inclusion, tolerance and equity in all interactions

### Why change is needed

Stigma and discrimination associated with mental illness occur across all levels of healthcare, government, the general community, workplaces, education and the media, with negative impacts for people with lived experience. Stigma reduces a person's ability to lead a meaningful and contributing life (NSW SFWP for Mental Health, 2018). Stigma can be caused by a person's lack of knowledge or misinformation about different types of mental illnesses, as well as their attitudes and behaviours (Beyond Blue, 2015).

Stigma identifies a person as 'different' (Canadian Psychiatric Association, 2011) and has been defined as:

*'a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society.'*  
(WHO, 2001).

People with a mental illness, and their families, experience significant levels of stigma and discrimination. Beyond Blue (2015) highlights the following different forms of stigma:

- > personal stigma – the stigmatising attitudes and beliefs that a person holds about other people
- > perceived stigma – the negative and stigmatising views that a person believes other people hold
- > self-stigma – the stigmatising views or beliefs that individuals hold about themselves
- > structural stigma – the policies of institutions (e.g. private and government organisations), as well as cultural norms, that restrict opportunities for individuals experiencing mental illness.

The experience of stigma can prevent people with mental illness from being able to meet their needs, which can lead to a less satisfying and contributing life (SANE, 2014).

Of note, this impact can be compounded for those who already experience stigma and discrimination because of the groups they identify with (e.g. people from CALD backgrounds, and those with an intellectual disability), which in turn may amplify the difficulties they experience in the mental health system and lead to inequalities in mental health outcomes.

Similarly, the experience of stigma can also affect the way mental health services and staff are supported, which in turn has impacts on the experiences of people with a mental illness.

## What is proposed?

### Recovery-oriented trauma informed services

Recovery-oriented, trauma informed services across all levels of South Australian mental health care are required in order to reduce stigma and discrimination. The WA Mental Health Commission (2015) highlights the key factors required in order to enable a recovery-oriented approach:

- > autonomy, self-determination and choice
- > co-design of individualised recovery plans
- > the involvement of those with lived experience (such as through the employment of peer workers), families, friends, culture and community
- > social inclusion, and actions that address stigmatising attitudes
- > the provision of family inclusive practice.

### Peer workforce

Peer workers refer to those people who have a lived experience of mental illness and recovery, and who are employed on the basis of having that experience (HWA, 2014; NMHC, 2018). In this way, peer workers are able to utilise the sharing of their lived experience to make valuable contributions to, and provide hope for, others who have a mental illness. Peer workers can be employed in various service settings, in a range of roles, including the provision of one-on-one support to individuals (eg helping individuals define personal goals, providing support, and advocacy), delivery of education programs, and facilitation of groups and activities.

Peer workers can inspire hope in others who experience a mental illness, particularly through sharing their recovery journey and their experiences of accessing mental health services. In addition, through their skills, training and education, peer workers are able to assist those with a mental illness to reduce the fear and self-stigma they might be experiencing (Salzer et al., 2013). They can work with individuals to develop new recovery strategies, and empower individuals to develop the skills needed to increase control of their own wellbeing. A strong peer workforce is particularly helpful in mental health services which support at-risk populations (e.g. people from CALD backgrounds, or people in forensic and correctional services) (HWA, 2014; NMHC, 2018).

## How will this be achieved?

- > Mental Health services will support the education of the community. Wellbeing SA will undertake strategies to reduce stigma.
- > A community awareness campaign across metropolitan and country as well as targeted training for specific workforces to improve community understanding and reduce stigma linked with mental ill-health.
- > Undertake targeted training for specific workforces in relation to responding to people experiencing mental distress to improve the ability of workforces to respond skilfully and compassionately to people experiencing mental distress through the provision of recovery based trauma informed training and service design.
- > Scope an anti-stigma initiative to specifically target stigma and discrimination experienced by those who are known to face inequality in service access across health services (such as those from CALD backgrounds or those who identify as LGBTIQ).
- > Funded mental health services to effectively address stigma, discrimination and adherence to human rights. This will be done in partnership with health promotion, NGOs and other agencies to:
  - promote good mental health and prevention programs
  - implement a zero-tolerance policy approach to stigma and discrimination regarding mental health and wellbeing in workplaces
  - embed recovery-oriented, trauma informed care into service delivery models funded and where possible partner across all services
  - increase access to various community mental health services (as an alternative to emergency department/ inpatient services which can be traumatising)
  - establish interagency process and infrastructure which supports social inclusion, and challenges stigmatising attitudes, and demonstrates mentally healthy workplaces and initiatives.
- > Funded mental health services will be commissioned with the expectation that consumers will have access to peer workers, and a peer workforce is developed.
- > Professional standards for the peer workforce will be applied in consultation with peer leaders and peer training programs.
- > Service designs will incorporate peer workers as integral components in the system of care.



## What are the measures of success?

- > Proportion of people receiving services who report feeling safe when accessing services and their individual needs and values are respected and incorporated in their care (YES survey).
- > Proportion of people receiving services who report a care plan was developed in partnership with them and considered all of their needs, including people with diverse cultural and linguistic needs (YES survey).
- > Assessing and measuring effective care and support from carers perspectives, where appropriate (CES) survey.
- > Staff values, attitudes and behaviours measured through workforce surveys.
- > A reduction in the proportion of people recovering/recovered from mental illness reporting experiences of stigma, reported in consumer feedback and/or via DHW's Safety and Learning System.
- > National Safety and Quality in Healthcare Standards are adhered to with the Comprehensive Care Standard being fully met and actively implemented by services.

## Outcome 11: The workforce is supported to provide the best care

The workforce has the capacity to provide mental health services to meet people's needs where they need it

### Why change is needed

There is a potential workforce crisis looming as a large proportion of our current workforce moves towards retirement. Workforce shortages, particularly in some geographic areas, are already a problem and this is expected to get worse.

The significant risk this poses to achieving improved mental health outcomes in the future cannot be overstated. Effort and resources need to be directed towards workforce planning to mitigate this risk.

In parts of our system, we are unable to fill vacancies and there are major shortages in country South Australia. There are not enough graduates coming through the training system and no strategic oversight of how many graduates we need in what disciplines to meet population needs.

Significant gaps in obtaining timely and accurate workforce data to inform workforce planning compounds the difficulties in taking the strategic view of the workforce. A long term view needs to be taken, using data to identify what we currently have and what the population will need.

Limited communication and lack of formal agreements between the public health system and the higher education sector is preventing a planned approach to student intakes.

At the same time capacity is limited to undertake supervision for graduates, which is significantly labour intensive. Some training programs have expanded, resulting in more graduates coming through without the equivalent expansion in clinical facilitators to supervise them in training.

Clinicians have expressed frustration at systems that prioritise administration over providing consumer care.

### What is proposed?

The workforce has the capacity to provide mental health services to meet people's needs.

- > The size and mix of the workforce is appropriate, sufficient and sustainable to meet the needs of the population.
- > A comprehensive understanding of future workforce numbers, skills and qualifications informs implementation of the initiatives in the Plan.
- > Workforce planning between DHW, NGO and the private sector, and the higher education sector informs student numbers, training places and recruitment strategies so that supply meets demand over time. In particular:

- improved workforce data is collected on current workforce, including the NGO and private sector workforces
- the workforce is available where it is needed
- all clinical and psychosocial interventions are of benefit to consumers
- students undertaking clinical placement are supported and supervised and retained in the workforce once graduated.

### How will this be achieved?

- > Medical, nursing and midwifery, and allied health workforce planning and modelling will build on existing modelling capability in DHW and be undertaken on a regular basis to ensure a collective agreement to the size and mix of the workforce.
- > In particular:
  - the roles of a specialist mental health nursing workforce will be maintained
  - the system will engage nursing staff in assessment and therapy roles as nurse practitioners and nurse therapists, supported by training
  - allied health staffing will provide evidence based discipline specific expertise.
  - support and educational roles will increasingly be undertaken by peers
  - the model recognises that consumers need evidence based interventions, and similar therapies can be delivered by practitioners from different backgrounds. Options for therapies will be increased through the engagement of an interdisciplinary team
  - peer workers will take on a planning and support role for consumers, be trained for their roles and have functions that are incorporated in the models of care
  - non-government services will increasingly provide case coordination and logistic support to clients leaving mental health clinics to focus on assessment and therapies
  - consumer care and support maybe shared with primary health providers in mental health, with state funded tertiary services providing periods of escalated support while ongoing care from other agencies continues
  - for this reason staff of our tertiary services will increasingly provide support to other services. Medical and psychiatry assessment and treatment resources will not only be available to treatment teams but also accessible to partner mental health services funded through primary health networks, and other agencies.

- > Establish a new state-wide supply and demand modelling process in collaboration with PHNs and peak bodies. Develop a joint process that takes into account the public (state government) workforce against all other workforce positions in South Australia including in primary care, the NGO sector and the private sector:
  - commissioned services will be expected to provide training opportunities for undergraduate and post-graduate students and staff across disciplines including providing places for peer trainees
  - this will be supported by the provision of accurate, well-defined workforce data which is collected and shared to inform workforce planning and modelling, and is reported on annually by DHW to inform the sector and educational providers
  - commissioning of rural and remote services will specifically recognise the need to provide attractive roles for medium and long term incumbents and a range of short term training positions and secondments with rights of return for staff from metropolitan services to experience rural and remote practice.

**11.1 Clear role definitions, competencies and standards ensure the workforce has the capability to consistently deliver the best care**

### Why change is needed?

There is a difference between the therapeutic interventions that ideally could be available and those that are available within the capability of the system. The workforce has the opportunity to diversify and provide a broad range of care options but the system needs to support clinicians to do this.

Myths and perceptions about different disciplines continue to raise barriers to effective collaboration. There continues to be a lack of awareness and understanding of the types of roles in mental health.

Clinical disciplines can operate within a broad scope of practice, and the allocation of roles and responsibilities within multidisciplinary teams need to reflect the opportunity and benefits of clinicians working to the top of their scope of practice.

### What is proposed?

- > Models of care that identify and support this.
- > Roles and competencies are defined by consumer care and treatment needs.
- > Roles build upon qualifications, competencies and standards.
- > Roles are clearly defined, with opportunities for staff to work to their full scope of practice.
- > Relationships are clearly defined, and multidisciplinary care is supported.

### How will this be achieved?

- > Endorse a set of professional core competencies for mental health services. Significant work has been undertaken on core competencies in mental health nationally and internationally. These competencies could be translated and adapted to the South Australian context for each discipline (including peers). Once endorsed, all staff – current and future, would need to demonstrate that they meet a set of minimum standards based on these core competencies for their discipline, in addition to having specific skills required for various areas of practice. This will be supported by standard role profiles and scope of practice documents.
- > Undertake an education and communication strategy to increase awareness of the types of roles and disciplines in mental health. Both the general community and the broader health workforce could benefit from increased awareness and understanding of the types of roles in mental health, as well as the unique contribution each discipline makes towards holistic mental health care.

## 11.2 The use of a professionalised peer workforce is expanded

### Why change is needed?

The peer workforce in South Australian mental health services is currently recruited and employed on an ad hoc basis in various pockets of the system. There has been little strategic planning at a state-wide level to identify the peer workforce needs within the mental health system. Evidence suggests that greater use of peer workers is beneficial in many ways (Salzer et al., 2013) but this evidence has not translated into broad or sustained changes to the composition of the workforce. The peer workforce is therefore not adequately funded.

Peer work is also not well understood within the health system. The inconsistent and ad hoc approach to peer work has resulted in inconsistent role descriptions and differences in the requirements for and responsibilities of different roles.

Often the only criteria required for a peer work position is to have lived experience of mental illness and a Certificate IV in peer work from TAFE SA.

Such matters are concerning. Peer workers can perform a variety of roles in ways that other mental health workers cannot. Peer workers complement the existing mental health workforce.

### What is proposed?

- > A professionalised peer workforce is supported to grow and expand in a strategic and consistent way.
- > Consistent selection criteria are developed and used to recruit and select peer workers.
- > Induction programs provide peer workers with the knowledge they need to operate effectively.
- > Career pathways provide opportunities for career advancement and appropriate levels of remuneration.
- > Roles are defined consistently across South Australia.
- > Clear guidelines provide advice to senior staff on the supervision requirements for peer workers.

### How will this be achieved?

- > Effective workforce planning for the peer workforce. DHW will audit the current peer workforce to identify gaps, and in conjunction with training providers, develop projections for a peer workforce. To support mental health providers peer experts and trainers will also be commissioned to support services to better match contemporary models of care and best practice in the utilisation of peers.
- > Consideration of a peer workforce component for all new projects and for existing services as they are re-commissioned. New projects and the redesign of existing services, such as implementing new models of care or looking at redesign of existing systems, will include an analysis and recommendation of the use of peer workforce.
- > Establish a peak body to represent, support, advocate for and represent the peer workforce, using existing resources.
- > Develop new options for training peer workers with universities. In collaboration with the university sector scope and develop requirements for training of the peer workforce that expands on the current Certificate IV offered through TAFE SA and considers the opportunity for undergraduate and postgraduate levels of qualification.

> Establish a human resources support hub for peer workforce recruitment. Develop a single knowledge base and support hub to provide advice and materials to mental health services to assist in the recruitment of peer workers, including information on:

- selection criteria
- screening tools
- role descriptions
- induction programs
- supervision requirements.

### 11.3 The workforce training and development enables the workforce to grow and excel

#### Why change is needed?

Training and development needs are both unique to each individual and may be consistent across particular roles and disciplines. The training needs that are based on discipline-specific core competencies need to be well defined and known to all staff in those roles and their managers.

Training and development can also be based on contemporary models of care and practise, and on improving identified areas of need across the state.

While running training and development programs can be costly, there are efficiencies in scale. The most significant cost and barrier to ensuring adequate training of all staff is the capacity of services to free up staff to attend training through backfilling positions. This creates a significant cost to services, and can also be challenging when substitute staff aren't available.

Training and development doesn't only apply to the professional workforce. There aren't consistent opportunities for training and development for some workforce cohorts, such as the peer workforce.

Policies may also hinder training and development being adopted in the workplace. Learning new skills and ways of working will be ineffective if the workplace can't or won't adapt to the changes brought back by staff.

There is also opportunity for non-mental health staff to benefit from mental health specific training, as many staff in general health areas or other social services sectors have never been taught the skills and knowledge for working in mental health even though they interact with the mental health system regularly.

#### What is proposed?

Mental health services provide the right training and development conditions for people to grow and excel:

- > general and discipline-specific training needs are identified through the development of core competencies based on evidence-based therapies
- > performance development supports all staff in continuous growth and lifelong learning
- > the workforce is trained in contemporary models of care including trauma informed and recovery-oriented care
- > the workforce is trained in culturally appropriate care
- > the non-mental health workforce has access to mental health training to improve the way it responds to consumers with a mental illness, even when the primary intervention is not mental health related.

#### How will this be achieved?

- > Approve a professional development plan for every person working in mental health. These plans would outline their current skills and abilities, areas for development based on the needs of the role, funding availability and a plan for how the training will be completed within the context of the service.
- > Provide access to mental health training for the non-mental health workforce. Additional training for non-mental health services staff, such as in Emergency Departments or SA Ambulance Service, would strengthen the ability of health services to provide care for mental health consumers. This would build on existing training that is available and may include:
  - Connecting with People suicide prevention and mitigation
  - trauma informed care

This will be provided by mental health staff and trainers. It will link to a program for non-mental health workers to spend time in mental health services for either brief visits, or short rotations. This would be to both community and inpatient settings.

## 11.4 People are attracted to working in mental health

### Why change is needed?

Negative perceptions of working in mental health as a career have grown over time. Mental health services have received negative media attention in the past, often because of the actions of a few individuals who have acted in ways that are inconsistent with the core values and beliefs of the vast majority of the system.

The diversity and variety of career options, pathways, roles and types of work in mental health is also not commonly understood. There is a gap in the promotion of mental health careers to students.

As well as being attracted to mental health initially, there is great benefit to people staying in the mental health workforce and building their expertise, experience and corporate knowledge.

There are opportunities to use robust selection processes against core competencies and values to introduce a workforce looking for longer term careers.

More can be done to keep staff engaged. Giving the workforce opportunity to pursue things of meaning and interest to them will encourage job satisfaction. The workforce also needs opportunities for their good work to be recognised.

With a critical workforce shortage looming in coming years, creating an attractive place to work will be necessary to encourage new graduates to choose careers in mental health.

### What is proposed?

Mental health services attract and retain the best people:

- > mental health care is a desired and attractive field of work for future generations
- > a diverse range of people work in mental health care
- > school children are exposed to and interested in the diverse and broad number of pathways in mental health that lead to rewarding careers
- > mental health care is promoted as a career option that aligns with a core set of values around care and compassion
- > graduate programs, traineeship programs, scholarships are regularly used as entry points for attracting new people into the workforce
- > people have the right fit, the right values and the right core competencies for the jobs they are appointed to

- > people are supported for long term careers that have growth, meaning and sustainability
- > people are able to pursue work of meaning and interest to them within the context of their role.

### How will this be achieved?

- > Promote a media campaign to encourage careers in mental health. A positive media and communications campaign aimed at young people in school and in higher education would identify the positive points of difference that makes working in mental health more attractive. The strategy could include positive stories of making a difference in people's lives.
- > Mapping out pathways into mental health careers would provide tangible examples to students of the diverse and broad range of roles they might like to pursue. This could be supported by interviewing students who complete a clinical placement within a mental health service and sharing their positive experience.
- > Increase workplace placements for students. Giving students the opportunity to visit, explore and experience mental health services first hand during the course of their studies provides an opportunity to capture their attention and embed a desire to want to pursue a career in mental health upon graduation.
- > Promote graduate programs, traineeships and scholarships as entry points. These programs provide pathways into mental health careers, as well as a solid basis of education and professional development. These can also be designed to encourage diversity of the workforce for various population groups or in geographical areas that otherwise may face significant barriers to entry.
- > Increase academic research and development activities. The opportunity to lead or contribute to research and development within a chosen field is a strong factor in retaining staff through providing a meaningful and engaging activity that promotes career development and contribution to a broader knowledge base.
- > Establish a statewide mental health showcase. A showcase of mental health initiatives, projects and services would allow for reward and recognition from peers, leadership and the general public. Showcasing exemplars of service excellence would increase job satisfaction while also raising the profile and image of mental health more broadly.

## 11.5 The workforce is mentally well and supported in the workplace

### Why change is needed?

While our workforce is there to provide the best consumer care, the workforce also has its own mental health and wellbeing needs.

Our workplaces are high pressure environments, but historically there has been an attitude that the workforce should be able to cope with these demands as it is just part of the job. Bullying and other code of conduct violations have occurred. Stigma and discrimination have been identified as potential reasons for the workforce avoiding coming forward and seeking help. The OHS&W system, including WorkCover, is still not viewed as treating mental injury the same as physical injury in practice, although legislation and policies have changed to try to rectify this.

In addition to this, the mental health workforce is a highly complex environment with sustained exposure to traumatic experiences.

When mental ill-health occurs in the workforce, it needs to be addressed early and comprehensively.

Government agencies, and in particular the public mental health system, have a lead role to play in modelling mentally healthy workplaces.

### What is proposed?

Staff of mental health services are mentally well and supported in the workplace:

- > our workplaces are mentally healthy, supporting and bringing out the best in our workforce
- > vicarious trauma of our workforce is acknowledged, and support services are provided
- > a culture of self-care is promoted and supported by policies that allow for time and effort to be directed towards self-care
- > employers model best practice in all workplaces
- > employers value and engage the workforce
- > middle management and executive listen and act on workforce issues
- > employers recognise the impact that may result from workloads, job design, working in complex and distressing environments, and bullying and other behaviours inconsistent with core values.

### How will this be achieved?

- > Implement the new whole of SA Government Mentally Healthy Workplaces Framework for the South Australian Public Sector 2019 – 2022. This is under development and being led by the Office of the Commissioner for Public Sector Employment, with input from all SA Government agencies. The Framework has been developed to support agencies to achieve:
  - an organisational culture that promotes engagement and mental health
  - a work environment that minimises the risk of mental harm
  - staff engagement in decisions affecting their mental health and wellbeing.
- > Local policies will need to be developed to implement the Framework at a local level to ensure that staff are aware of, and able to access, various programs and activities that support staff to manage and maintain their own mental health and wellbeing. Policies may cover such activities as:
  - the use of special leave to undertake volunteering
  - walking and exercise opportunities available locally
  - quit smoking programs
  - Employee Assistance Programs.
- > Provide training opportunities to equip mental health service leaders with the right tools and training to ensure they are able to respond to the needs of staff. Middle manager skills and knowledge could be improved in the areas of:
  - recognising and supporting mental health issues in the workplace
  - managing bullying and other code of conduct matters
  - resolving conflict
  - building resilience
  - having effective performance conversations.



## 11.6 New and innovative ways of working are supported

### Why change is needed?

Our workforce can't work together unless there are appropriate processes to enable flexibility and innovation to support mobility and flexibility across services so that they can provide the best care to the community.

Existing systems may also present a barrier to trialling new ways of working. New and innovative roles often need significant support, time and effort to be developed. For example, the development of Nurse Practitioners occurred over 20 years in Australia and significant benefits have since been demonstrated from the investment in developing that role over time.

There also needs to be the appropriate levels of credentialing, standards and clinical governance to safely support the transferability of the workforce across services, so that consumer safety and quality isn't compromised.

The need to develop new ways of working can also be forced upon the system, through policy or funding changes that impact on the workforce. For example, changes to funding under the NDIS will result in structural changes to the composition of the NGO workforce, while the need in the community still remains.

### What is proposed?

Workforce flexibility, mobility and innovation are supported to best meet people's needs:

- > the workforce is supported by systems that put the consumer first
- > locations, service modalities, and hours of operation are designed to flexibly respond to the needs of the population
- > credentialing, minimum standards and clinical governance support safe ways of working across sites, services and organisations
- > flexible funding and policies allow the workforce to work across organisations
- > information is shared across disciplines and different organisations
- > staff are supported to trial or pilot national and international models of best practice
- > innovation is encouraged and safe spaces are created to try new things.

### How will this be achieved?

- > Flexible employment arrangements to support backfill and provide job opportunities. Commissioning of services to support secondments, short term projects and job sharing across departments and sectors could be promoted. This would encourage staff to try new things, gain new skills and be exposed to new perspectives, all of which they then bring back to their workplace following the completion of the placement.
- > As new services models are developed and services refined across the various continuums of care, funding may need to be reallocated to support backfill and a change in staffing models over time. This process will also include how existing funding could be used more effectively, while recognising that investment in new initiatives will be needed to achieve a more integrated, efficient and sustainable mental health system into the future.
- > Implement the Office of the Commissioner for Public Sector Employment (OCPSE) determination on public sector mobility. The OCPSE has issued a determination that requires public sector agencies to support the mobility of the workforce. A Department implementation plan for this determination could ensure that disruption to business continuity is minimised, and that the funding and approvals processes are addressed in a consistent way across LHNs.

### What are the measures of success?

- > Decreased duration of unfilled vacancies.
- > Increase the number of available facilitated student placements in mental health services.
- > Increase in new graduates seeking employment in mental health services.
- > Number of supervised training positions in DHW mental health services.
- > Increase in the number of peer worker positions in DHW mental health services.
- > Improvements in workforce wellbeing and satisfaction measure through staff surveys.
- > Decrease in WorkCover injury claims for psychological distress.
- > Improved recruitment and staff retention rates.
- > Increased uptake and engagement in training opportunities, including peer workforce training.

# 6. Considerations for implementation

The Plan outlines the allocation of resources to mental health services in the government, NGO and private sectors, and then monitors performance.

Responsibility for implementing much of the change associated with the Plan will rest with the new governance of Local Health Networks. Boards and executives will need to prioritise mental health service improvement, and also steward the State's financial investment in mental health services wisely. Funds allocated to mental health will need to be productively spent on mental health, and special scrutiny will be needed to ensure that State investments for specific population groups benefit those groups. Cost centre budgets will need to be meaningfully constructed so that managers can take responsibility for the safe and efficient expenditure of these funds.

Service Integration is a fundamental goal of the Plan. Within services this can occur when inpatient and acute community services are delivered by the one provider. However, past assumptions that funding one LHN exclusively in a geographic area to deliver a comprehensive range of services for that area, in the expectation that they will integrate effectively has not always proven successful. Any region of our state may now have multiple Commonwealth and State funded providers who need to operate collaborative referral and partnership arrangements, and increasingly LHN services will need to provide assessment and specialist assistance to the consumers of PHN services at times when they are more unwell. Exclusive geographic regional services will not be assumed in the Plan. This will mean that a high performing LHN service with satisfied consumers and staff may be commissioned to provide state-wide services and potentially operate clinics and mobile services in other LHNs catchment areas. Some specific community services and clinics that might ordinarily be assumed to be government operated by a local LHN will be tendered for all LHNs, the Non-government and private sector to bid for.

While boards will be accountable for implementing change at a local level, this governance arrangement will be closely monitored. If it is not delivering improved outcomes with speed and purpose, alternative governance arrangements for Mental Health Reform will be considered.

Implicit in the above considerations it is unlikely that any LHN, even a large high performing service, can be self-sufficient for mental health care, and will need to rely on other LHNs to meet some consumer's needs. This includes access to sub-specialist services, statewide services, and acute inpatient beds when one LHN's beds are full and another LHN has capacity. This will be recognised in commissioning arrangements which will include requirements for operators of statewide services to consider the strategic needs of other services, and permit LHNs to collaboratively support each other to manage demand, and provide specific sub-specialist services on a statewide bases (for example disability and mental health.)

The performance of mental health services will be monitored in regard to the implementation of the Plan. Each initiative will have quality performance measures and a range of key performance indicators to monitor service access, effectiveness, efficiency, quality and safety, responsiveness. These measures will be developed and agreed with our services partners as well as consumers and carers.

## 6.1 Governance

A governance framework will be formalised to support implementation and evaluation of the Plan.

The accountability for implementing the Plan rests with key leaders with different authority. As the Plan guides the commissioning of services, the Chief Executive of Health has ultimate oversight. The Plan also has a strong emphasis on therapeutic interventions, trauma informed and personalised care, upholding rights, and the safety of services, all of which fall within statutory duties of the Chief Psychiatrist.

When it comes to service design, operationalisation, and achieving goals for specific locations and population groups, accountability will rest with the Boards of LHNs and NGOs that have been commissioned to deliver the outcomes of the Plan.

It is expected that the Chief Psychiatrist will convene an Implementation Oversight Group, on behalf of that Office, and the Chief Executive to guide implementation, and monitor the achievement of goals against the Plan. An oversight group will meet for the life of the Plan.

The existing Department Mental Health Leadership Group which has LHN and lived experience representatives will provide a forum for collaborative action across LHN operated services and DHW. This will ensure that statewide services required by this Plan are delivered in a coordinated way and LHN services can provide mutual assistance when required.

## Organisational Change Management

The Plan is designed to change the fundamental way services are delivered across LHNs and with service partners. This may involve resource re-prioritisation and new services.

Change can create anxiety for consumers, family members, carers and staff, and as a consequence, it will be necessary to develop a comprehensive change management plan to support implementation. This may create the need for training and development resources as well as a suite of communication and information tools.

The cost of the change management program has not yet been determined, but will be undertaken as part of the Plan's implementation.

# 7. Monitoring and review

Along with other governance sources, the measures of success within the Plan will be used to monitor progress. The Plan Implementation Oversight Group will consider if new ways of collecting information need to be invested in. These complementary measures will be used to provide a clearer picture of change within the mental health system, and whether the system is meeting the needs of people with mental illness.

## Performance Accountabilities Framework

Mental Health Services will use the South Australian Performance Accountabilities Framework which is currently being updated by DHW. This sets out the framework within which DHW monitors and assesses the performance of public sector health services in South Australia. It includes the performance expected of health services to achieve levels of health improvements, service delivery and financial performance as set out in their Service Level Agreements (SLAs).

## Evaluation

The Plan will be evaluated progressively over the first three years to monitor implementation and outcomes being achieved. The implementation of the plan will be formally reviewed at three time points: 18 months, three years and at five years with agreed performance expectations linked to each review stage.

- > At the 18 month mark, existing performance indicators for service access, outcomes, and quality will have improved so that South Australia's performance is better than the national average. This will include Emergency Department performance for adults, reductions in restrictive practices, and improved access to quality services for young people, adults and older adults.
- > By the three year mark these improvements will be sustained and be accompanied by the implementation of the innovative service types described in the plan, greater access to therapy and peer services, and common access points for some services (for example Youth), with substantial progress to deliver best practice across the state.

- > By five years measured clinical outcomes, consumer satisfaction and staff satisfaction with work will have improved so that our services meet the highest Australian benchmarks, and in some areas meet international best practice. Linked to a suicide reduction initiative in services, there will be a reduction in mortality of consumers receiving specialist care, and due to the rights based elements of the plan, there will be less use of restraint, seclusion and involuntary orders.

The success of the Plan will be independently reviewed with a final evaluation report completed at the end of the Plan's five year period. This will inform the development of the next Department Mental Health Services Plan

# Appendix 1 – Project Governance Structure

## Interdepartmental Executive Group.

To oversee the Plan and steer its high level direction as a collaborative effort between DHW and the SA Mental Health Commission, the following leadership was convened.

- > John Brayley (Chair) – Chief Psychiatrist
- > Chris Burns CSC – SA Mental Health Commissioner
- > Jennifer Williams AM – Independent Advisor

## Project Steering Group

The Project Steering Group oversaw the work of project workgroups, and integrated this into an overall systemic plan. Executive support for this group was provided by the Office of the Chief Psychiatrist.

The key functions of the Project Steering Committee were to:

- > provide effective leadership for the development and implementation of the Plan;
- > establish a project plan highlighting strategic objectives and key performance indicators;
- > support analysis of current data and ensuring the ‘future proofing’ of mental health services;
- > promote partnerships that facilitate an integrated approach to mental health service planning and delivery; and
- > ensure consumer, carer, community and stakeholder engagement and participation mechanisms for mental health service planning.

Chair	John Brayley Chief Psychiatrist	Professional and sector engagement
Deputy Chair	Chris Burns Mental Health Commissioner	Lead, community engagement
Deputy Chair	Jennifer Williams	Independent Advisor governance advice
Deputy CE Department for Health and Wellbeing	Don Frater	Lead finance and business engagement
LHN Chief Executive Officer	Lindsey Gough	Lead, LNH Executive Engagement
LHN Clinical/Chief Operating Officer	Scott McMullen	NALHN
People with lived experience	Matt Halpin Jen Coulls Heather Nowak	
Aboriginal leadership and advocacy representative	Dr Roger Thomas	Commissioner for Aboriginal Engagement (DPC)
Non-government sector	Geoff Harris	Mental Health Coalition of South Australia
CALD leadership and advocacy	Enaam Oudih	
Other work group chairs	Catherine Turnbull Sharon Lawn Jo Hoiles Anne Burgess	Represented in work groups
Drug and Alcohol Services, South Australia	Mike McDonough	Clinical Director, DASSA
CEO, Primary Health Network	Deb Lee	Adelaide PHN
Senior Clinicians	Dr Daniel Moseler (Medical) Shane Moyle (Allied Health) Pat Mead (Nursing)	

## Plan Work Groups – Defined by Themes

Specialist Work Groups were created to provide expertise and input to six overarching themes:

- > Wellbeing and prevention (Chair: Chris Burns)
- > Access to services (Chair: Catherine Turnbull)
- > Continuity of service (Chair: Anne Burgess)
- > Recovery and rehabilitation (Chair: Sharon Lawn)
- > Service excellence (Chair: John Brayley)
- > Workforce (Chair: Jo Hoiles)

All groups had internal and external members with broad representation including lived experience and higher education sector. Groups contributed papers and other written material to inform the Plan as it related to their allocated theme.

- > The purpose of the work groups was to develop content for inclusion in the Plan that relates to the relevant theme, including:
  - the current state of services (baseline data)
  - summary and analysis of best practice and evidence based planning (such as the National Mental Health Services Planning Framework)
  - summary and analysis of the experience and feedback of stakeholders, including people with lived experience, clinicians and service providers
  - analysis and development of the outcomes sought, the level of services that need to be provided to meet those outcomes and the opportunities for practice change and innovation to meet future demand
  - recommendations and content based on the above to be included in the Plan.

## Population and Service Groups across the Work Groups

The following are the key service categories that Work Groups had to consider within the development of projects outputs in relation to their theme:

- > Child and Adolescent Services and Young People's Services
- > Adult Services – Acute and Rehabilitation
- > Services for Older People
- > Forensic Mental Health Services
- > Aboriginal Mental Health Services
- > Services for people in isolated rural areas
- > CALD services
- > First responders

- > Adult ADHD
- > LGBTQI
- > Integration with substance abuse services
- > Integration with disability services.

For each service category the work groups coordinated their approach to ensure consideration for the following:

- > description of the characteristics of the people within their specified population groups who need a service currently, and into the future
- > description of the current interventions that need to be delivered
- > description of the future interventions that may influence delivery
- > description of the best evidence targets and what will be required to meet these
- > description of appropriate outcome measures, currently available and what will need to be developed to measure the success of the promotional activity, intervention or service
- > description of appropriate quality measures currently available and what will need to be developed to measure the safety and quality of the promotional activity, intervention or service
- > potential capital requirements, both currently and for the next five to ten years
- > potential required staffing mix to ensure the promotional activity, intervention or service is successful
- > regular monitoring and progress reports and a final report to the Program Steering Committee regarding the deliverables.



# Appendix 2 – Consultation Process

## Key Stakeholders

- > Chief Executive, Department for Health and Wellbeing
- > Chief Executive Officers, LHNs / SAAS (Department for Health and Wellbeing Strategy and Governance Committee)
- > Clinical leads and staff representatives of Local Health Networks
- > Mental health lived experience groups
- > Primary Health Networks
- > Mental Health Services Clinical Directors and Directors of Strategic Operations
- > Non-government mental health sector
- > CALD peaks and representatives
- > Aboriginal Health peaks and representatives
- > Other Government partner agencies e.g. Department for Correctional Services, Department for Communities and Social Inclusion, Department for Education
- > First Responders
- > Professional Groups
- > Industrial Groups
- > Public Advocate
- > Principal Community Visitor
- > Aboriginal Health Commissioner
- > Health and Community Services Complaints Commissioner
- > Health Consumers Alliance
- > South Australian Mental Health Coalition
- > Carers SA

## Community Consultations

- > Forums – 13 November 2019 and 13 Decemebr 2018
- > YourSay website

## Consultation Forums with Industrial Bodies and Professional Groups

### Initial forum dates:

Industrial Groups – 7 November 2018

Professional Groups - 8 November 2018

### Follow up forum dates:

First Responders Group Forum – 8 January 2019

Industrial Group Forum - 8 January 2019

Professional Group Forum – 9 January 2019

### Participating agencies:

#### *Industrial Groups*

- > South Australian Salaried Medical Officers Association
- > Australian Nursing and Midwifery Federation
- > Public Service Association SA

#### *Professional Groups*

- > Royal Australian College of General Practitioners
- > Royal Australian & New Zealand College of Psychiatrists
- > Australian College of Mental Health Nurses
- > Occupational Therapy Australia
- > Australian Association of Social Workers
- > Australian College for Emergency Medicine
- > Australian Medical Association

#### *First Responders*

- > SAPOL
- > SA Ambulance Service
- > Metropolitan Fire Service
- > Royal Flying Doctors Service

# Appendix 3 – Mental Health Indicators

## Mental health indicators – current

Indicator	Population / Category	Target
<b>Inpatient Acute</b>		
ALOS Linked (General acute)	Adult	1-14
28-day readmission rate (General acute - linked)	Adult	12%
(readmission to any hospital)	OPMHS	12%
Journeys > 35 days: No of journeys	Adult general ac.	
Journeys > 35 days: % journeys	Adult general ac.	
Admitted patient acute Occupancy	Adult general	90%
	Specialist	90%
	OPMHS	90%
	MH Short Stay	65%
LOS > 35 days (Acute inpatient - non-linked)	Adult	TBD
(Separations %)	Older Persons	TBD
<b>Emergency Departments</b>		
ED Visit Time (Hours)	All	6 Hrs
ED Visit Time %	<=4 Hrs	90%
	<=8 Hrs	95%
	<=16 Hrs	100%
	<=24 Hrs	100%
ED Wait Time To Admission	LE 4 Hrs	TBD 90%
	LE 8 Hrs	TBD 100%
	LE 24 Hrs	TBD 100%
	GT 24 Hrs	TBD 0%

*Continued*

Indicator	Population / Category	Target
<b>Inpatient non-acute &amp; Residential</b>		
Admitted patient occupancy	Adult	90%
	Older Persons	90%
	Forensic	90%
Admitted patient ALOS (non-acute)	Adult	TBD
	Older Persons	TBD
	Forensic	TBD
ICC ALOS (days)		5-14
ICC Referral Source	Inpatient	30%
	Comm. MH	27%
	ED	35%
	Psych Facility	2%
	Other	6%
ICC Separations		260
CRC ALOS (days)		180
CRC Separations		140/yr (82 YTD)
Residential OPMHS Occupancy		85%
<b>Community</b>		
Post-discharge	Adult	80%
Community Care	Older Persons	80%
(7-day follow-up rate)	CAMHS	80%
Pre-admission	Adult	60%
Community Care	Older Persons	60%
(7-day pre-admission contact rate)	CAMHS	60%
Community Contacts	Adult	TBD
	Older Persons	TBD
	CAMHS	TBD

## Mental health indicators – proposed

Tier	Indicator	Measure
1	Mental Health Discharge Follow-up	% of acute mental health inpatients followed-up in the community with 7 days
1	Mental Health Readmission	% of acute patients that are readmitted within 28 days of discharge (child & adolescents, adults and older persons)
1	Rate of restraint	Mental Health restraints per 1,000 bed days
1	Rate of seclusion	Mental Health seclusion rates per 1,000 bed days
1	Patients in ED > 24 hours	% of patients waiting in ED more than 24 Hours
1	Suicides in inpatients Units	No. of deaths by self-harm in inpatient or residential services
Tier	Indicator	Measure
2	Acute average length of stay	% of patients with an average length of stay > 14 days in an acute unit (excluding short stay units).
2	Involuntary Community Patients	% of involuntarily community patients
2	Peer workers	% of direct care mental health clinical that are peer workers
2	Patients > 35 days	% of patients with a length of stay > 35 days in an acute inpatient unit.
2	Residential Occupancy Rate	% of beds occupied in a specialised residential facility
2	Patient Admission Rate	% of patients admitted to an acute unit from an emergency department
2	Community Client Review Rate	% of community clients reviewed within 91 days

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