Central Adelaide Local Health Network
Mental Health Directorate

Community Mental Health

Model of Care

(Ages 16 – 65 years)

June 2019
Version 2.0

Government of South Australia
SA Health

Contents

Acknowledgement

With the combined efforts of staff, consumers, carers, our mental health partners and both Southern Adelaide Local Health Network (SALHN) and Northern Adelaide Local Health Network (NALHN), the Central Adelaide Local Health Network (CALHN) were able to create this Model of Care. We are grateful for all involvement and would like to give acknowledgment to:

- consumers and carers who attended our workshops, project meetings, responded to our online survey via SurveyMonkey and provided feedback from a mental health lived experience background. This insight allowed us to gain knowledge on what our consumer's and carers' value most when seeking help from our service.
- our multidisciplinary mental health staff members who have been involved by attending and engaging in workshops, being present at staff forums, providing feedback, facilitating events, taking part in committee meetings and helping form the model of care.
- our partners who have participated in workshops and committees which have informed the development of this paper.
- SALHN and NALHN who preceded CALHN in the Community Mental Health (CMH) Redesign. Your shared knowledge, experiences and lessons learnt have helped lead this process.

We would like to acknowledge this land is the traditional lands for the Kaurna People and that we respect their spiritual relationship with their country. We acknowledge that the Kaurna people are the custodians of the Kaurna land and that their cultural and heritage beliefs are still important to the living Kaurna people today.

Document Control

Document owner	Co-Chairs Community Mental Health Redesign Project Committee: > Dr Leslie Stephan, Clinical Director Mental Health Directorate (MHD), CALHN > Lesley Legg, Nursing Co-Director, MHD, CALHN
Title	CALHN, Community Mental Health, Model of Care. (Ages 16 - 65 years). V2.0
Description:	The Community Mental Health Model of Care is a conceptual document with the aim of best practice service delivery, core business aligned to guiding principles
Subject:	CALHN Community Mental Health (16 - 65 years)
Contributors	Expert Advisory Group (EAG) Workshops dates: 11/12/18, 15/1/19, 08/2/19, 07/3/19 Consumer and Carer Forum: 21/2/19, 03/5/19 CALHN Consumer Advisory Group CALHN Community Mental Health Project Management Committee CALHN Community Mental Health Executive Governance Committee Consultation and Feedback from 8/4/19 until 6/5/19
Document location	MHD Executive Team\Community Mental Health Redesign Project\1. Model of Care

Document History

Version	Effective from	Effective to	Change summary
Draft	29/03/19	03/04/19	Draft document approved by Governance Committee. Minor changes made throughout. Additions made to executive summary. Formatted.
1.0	04/04/19	03/05/19	First version for consultation. No changes made during this period.
2.0	26/06/19	N/A	Changes made considering feedback from consultation period. Endorsement signatures and dates added.

Endorsement / Sign off

Name	Title	Signature	Date
Lesley Legg	Nursing Co-Director, MHD, CALHN	J.Legg	26/06/19
Leslie Stephan	Clinical Director, MHD, CALHN	L Stephan	26/06/19
Bronwyn Masters	Executive Director Operations, Royal Adelaide Hospital		27/06/19

Executive Summary

The Central Adelaide Local Health Network (CALHN) Community Mental Health (CMH) service is located in two sites at Tranmere and Woodville. Currently there are approximately 2000 consumers engaged in the CMH service. CALHN CMH services provide tertiary mental health services for youth and adults aged between 16 – 65 years with an underlying psychiatric illness.

The CALHN CMH service is a multidisciplinary service providing dynamic, flexible and responsive care based in the home and community. Services are provided with compassion, dignity and respect between clinician and consumer.

Since 2007, CALHN CMH services have undergone several reviews with the most recent of these being undertaken in 2015. The Department for Health and Wellbeing commissioned Deloittes consultants to assess and analyse the efficiency and effectiveness of the CMH service across metropolitan Adelaide.[7] The objectives of the review were to identify options to build the capacity in CMH services and improve the access and continuity of care for people living with mental health difficulties / illness. In November 2018, CALHN CMH commenced the first of three phases in the CMH redesign project. These phases include:

1. Development of a CMH Model of Care (Nov 2018 – Apr 2019).
2. Development of a CMH Service Plan including staffing modelling (May – Dec 2019).
3. Implementation and evaluation (Jan – Aug 2020).

The CALHN CMH Model of Care is the first of a suite of strategic documents that will provide a framework for the guiding principles, core business, priority areas, service provision, operational and strategic planning priorities and directions.

The CALHN CMH Model of Care describes our vision, our values and guiding principles. The guiding principles embrace consumer centred care, evidence based practice, collaborative partnerships, recovery oriented care, valuing and developing staff and outcomes/evaluation. Shared cared with other providers is the foundation of our service delivery. Transfer of care is supported by rapid re-entry pathways into CMH.

The way our staff work underpins how we provide safe, high quality consumer centred care. Staff are recognised for their skills and abilities and will be supported to continually develop.

As a tertiary specialist CMH service, core functions include services provided to people aged 16 – 65 years with a major psychiatric illness or experiencing a mental health crisis, those with a borderline personality disorder, those who have a mental illness complicated by substance misuse, individuals responding to suicidal ideation as well as the provision of specialist psychiatric assessments and advice. Where referrals are received for conditions that can be managed by other specialist services (drug and alcohol conditions; intellectual disability; attention deficit hyperactivity disorder; autism spectrum disorders; acquired brain injury and dementia) CALHN CMH services will engage with primary service providers in the development of collaborative pathways to enable referral to the appropriate service provider.

The CMH services will provide an acute care function supporting short term assessment and interventions. Those consumers requiring longer term support will be provided with medium or long-term specialist care and psychosocial interventions.

CALHN Mental Health have selected four priority areas which are suicide response and prevention, trauma informed care and practice, youth mental health (16 – 25 years), and physical and mental health.

What is a Model of Care?

A model of care is a multifaceted concept, which broadly defines the way a health service is delivered. This model of care is a conceptual model that underpins the delivery of CALHN CMH services that outlines:

- best practice
- statements of care that underline our guiding principles and values
- our core business and defines who our consumers are.

This model of care was developed through extensive consultation with CALHN Mental Health staff, consumers and carers and external agencies via workshops, staff forums, on-line surveys and emails. Many staff, consumer and carer contributions have been included in this document to contextualise a consumer centred care approach towards a model of care.

The model of care will continue to change over time to reflect research and evaluation, the results of continuing consumer, carer and stakeholder contributions plus political and social implications.

Ultimately the model of care aims to ensure the CALHN CMH service, consumers, carers and wider community receive timely, effective and efficient care underpinned by non-negotiable guiding principles.

Central Adelaide Local Health Network

Community Mental Health Services

Our Vision

To provide consumer centred mental health care that enables recovery, identifies and prevents mental illness early[1] to enable consumers to feel valued and empowered and to 'reconnect with family, community, work and study' without 'guilt, shame stigma or judgement.'

Our Values

- To actively listen and not judge.
- To show compassion and empathy.
- To be genuine and inclusive.
- To empower and foster optimism.
- To respect and encourage.
- To manage stigma.

(CALHN Consumer and Carer Forum, February 2019)

Summary of Guiding Principles

CALHN CMH services has six guiding principles that define and lead how we work with our consumers, carers, our colleagues and partners in the daily delivery of mental health services every day.

1. **Consumer centred care**

   A CMH care system is designed around the consumer, carer and family with respect for a person's preferences, values and needs.[2]

2. **Evidence based and informed practice**

   To provide safe and high-quality evidenced based interventions, treatments and therapies.

3. **Collaborative partnerships**

   To build collaborative partnerships that enhance the efficiency and quality of service provision for all consumers and carers.

4. **Recovery oriented**

   Respect and value the real life, deeply personal and unique experiences and challenges of mental health disability or illness.

5. **Value and develop staff`**

   To recognise and value the skills, experience, diversity, goals and skills of all staff. To empower staff to work at their optimum level by being mentally and physically well.

6. **Outcome and evaluation**

   To measure and evaluate key consumer and service outcomes to improve our service delivery.

(CALHN Staff Clinical Expert Advisory Workshops, December 2018 - February 2019, Consumer and Carers Workshop, February 2019)

Background

Rationale

CMH services have undergone several reviews since the 'Stepping up; a social inclusion action plan for mental health reform 2007 – 2012'.[3] This included the review of Community Mental Health Services in South Australia 2008[4] that resulted in the implementation of a collaborative integrated mental health system where all members of the multi-disciplinary team fulfilled the function of a care co-ordinator for a designated part of the consumer group and manage all components of the consumers mental health care.[5,6]

In June 2015, the Department for Health and Wellbeing (DHW) commissioned a review of CMH services by external consultants. The report provided recommendations relating to models of care, organisational and operational structures, training and development.[7] A response from the DHW in March 2017 accepted the majority of the recommendations.[8]

The recommendations included:[8]

1. Define core business in line with refined primary care models and commissioned services.
2. Refine the operating model with implementation of acute community and ongoing community streams.
3. Revise current business rules to provide a more flexible framework and standardisation.
4. Review and enhance the mental health triage process (*not supported by DHW*).
5. Model staffing within the acute and ongoing community streams based on the referral patterns and transfers needed to primary care or to self-managed care.
6. Support development of rapid access assessment.
7. Identify the skills and supports required for each phase of care and allow health professionals to practice at the top of their scope.
8. Implement mechanisms for review of consumers after a set number of sessions. Initiate early discussion with consumers and carers regarding progress and transfer to shared care.
9. Enhanced primary care and non-government organisation interfaces and capacity development support.
10. Implement 'Shared Care' as the default option for all ongoing care consumers.
11. Consider trialling community transfer of care positions facilitate shared care and closure of consumers with long lengths of stay.
12. Streamline care plans and reduce the amount of time required for documentation.
13. Investigate refinements to Community Based Information System (CBIS; a primary clinical community database) functionality.
14. Implement Community dashboards with targets and flow expectations.
15. Invest in the development of frontline team managers to understand flow, accountability and performance management.

The CALHN CMH Model of Care has been guided by these recommendations and actions proposed by the DHW in the context of National and State based strategic plans and frameworks.

Strategic Alignment

National Context

The Fifth National Mental Health Plan[1] (the Fifth Plan) sets out a national approach for collaborative government effort over the next five years. The Fifth Plan recognises that consumers and carers need to be at the centre of the way in which services are planned and delivered, and that a regional focus is a key platform of the change.

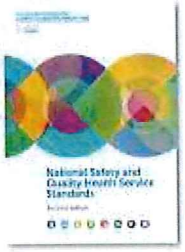
National Mental Health Service Planning Framework[9] is a population planning model that provides a nationally consistent approach to service planning. It combines best evidence on mental illness prevalence and service needs, the types and levels of care required for different target populations, and efficient standards of mental health service operation.

State Context

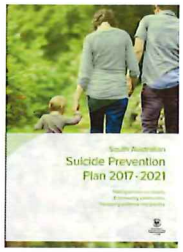
The SA Health Strategic Plan (2017 – 2020)[10] is a vision for SA Health from 2017 – 2020 and sets priorities and a framework for planning and decision-making across SA Health.

The South Australian Mental Health Strategic Plan (2017 – 2022)[11] has drawn upon the input from thousands of people across South Australia. This work was conducted at local, national and international levels in mental health and wellbeing reform. The SA Mental Health Strategic Plan translates our vision into three core strategies underpinned by seven strategic directions.

The South Australian Mental Health Services Plan (MHSP) due to be released in 2019, will build upon the vision and direction in the SA Mental Health Strategic Plan. The MHSP will chart the future direction for SA Health operated and commissioned mental health and wellbeing services and describe the outcomes users can expect and the range of services to meet population–based needs.



The National Safety and Quality Health Service (NSQHS) Standards (second edition, Nov 2017)[12] provide a nationally consistent statement of the level of care consumers and carers can expect from health service organisations.



Other state legislation includes the **South Australian Mental Health Act 2009**[13], The **South Australian Suicide Prevention Plan** (2017-2021)[14], and Pathways to Care Policy Directive[15] (2014) will continue to guide the strategic directions and model of care of the CALHN community redesign process.

The South Australian **Carers Recognition Act 2005**[16] recognises and supports carers in their role in the community.

CALHN Context

CALHN is responsible for promoting and improving the health of people living in central metropolitan Adelaide and the broader community, through the delivery of integrated healthcare and hospital services. CALHN covers central, western and eastern suburbs of metropolitan Adelaide, serving a community of over 466,000 people.[17] CALHN is committed to the delivery of quality and sustainable healthcare to ensure we provide integrated, respectful and safe patient centred service to our diverse communities.

The annual budget of CALHN is over $2 billion and is a large, multi-site organisation with a workforce of over 13,000 staff.[17] It encompasses six major hospitals and campuses; the Royal Adelaide Hospital (RAH) as a major tertiary facility, The Queen Elizabeth Hospital (TQEH) as a general hospital, and rehabilitation hospitals Hampstead Rehabilitation Centre (HRC) and St Margaret's Hospital (SMH), and a significant number of mental health and primary health care services.

CALHN also governs a number of state-wide services including Glenside Health Services, Rehabilitation Services, SA Dental Service (SADS), SA Prison Health Service (SAPHS), SA Cancer Service (SACS), Breast Screen SA (BSSA), Donate Life SA (DLSA), and State-wide Clinical Support Services incorporating SA Pathology, SA Medical Imaging and SA Pharmacy.

In the new governance environment of SA Health, governing boards are being established in each local health network. The establishment of the CALHN governing boards will support local decision making about health service needs as close as possible to where consumer centred care is delivered. This will enable the delivery of a safer, high quality and financially sustainable health system now and into the future.

CALHN Mental Health Services

CALHN Mental Health Services

The CALHN Mental Health Directorate (MHD) is responsible for the mental health services at the three major hospital sites (RAH, TQEH and Glenside Health Services), four community centres, and two community residential units.

The diagram below outlines the current CALHN mental health services. Note: CMH services at Tranmere and Woodville, including the Youth Mental Health Service, are in-scope for the CMH Model of Care. All other services in the diagram below are considered out of scope for the purpose of this document.

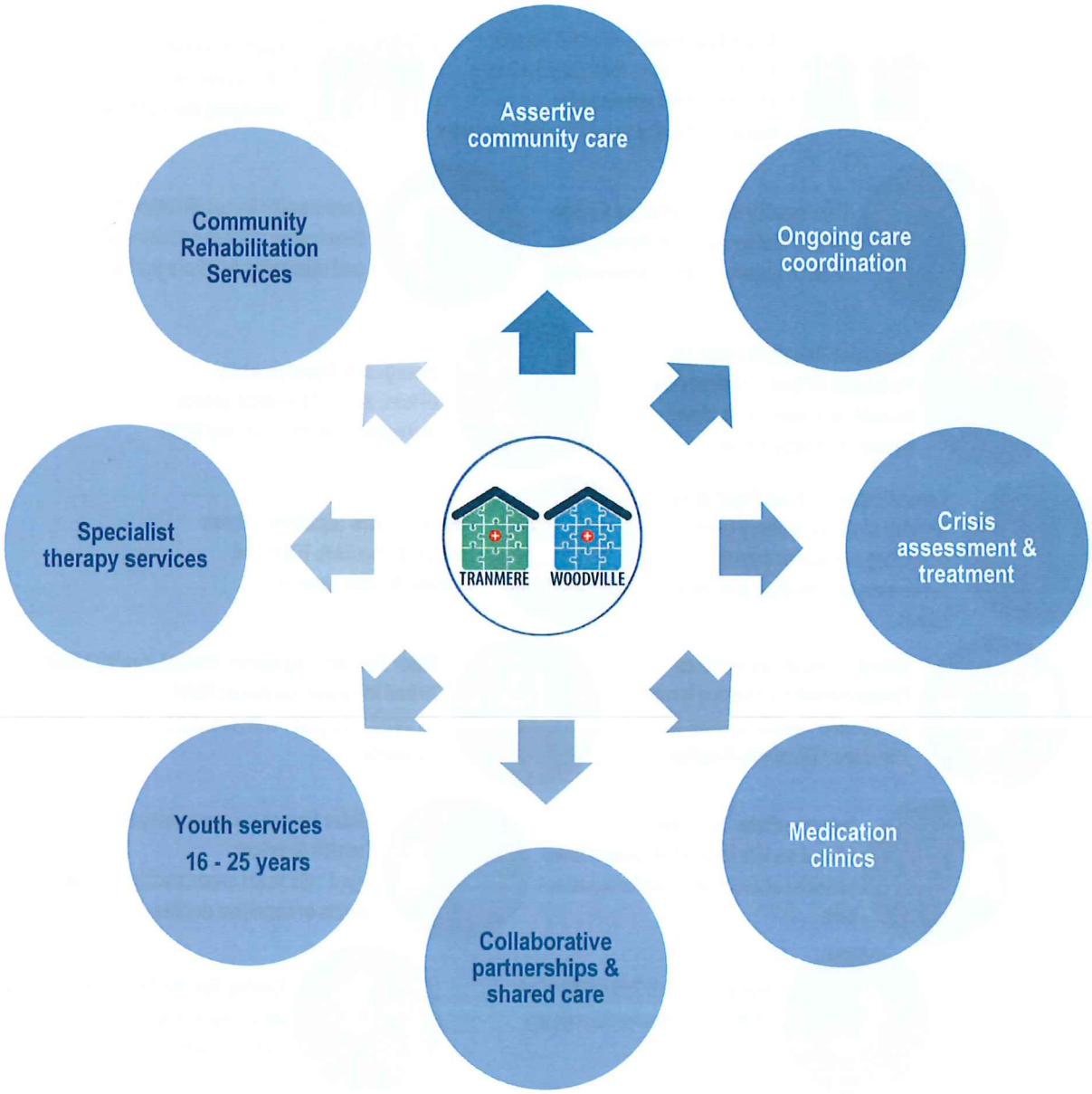
Current CALHN Mental Health Services are:

CALHN Community Mental Health Services

CALHN CMH services provide specialist tertiary mental health treatment to consumers aged from 16 – 65 years, with an underlying psychiatric illness, in their own community. There are currently approximately 2,000 consumers at any point of time engaged with our CMH service. CMH services are located at Tranmere and Woodville.

Treatment is offered by a multidisciplinary team including medical officers, nurses, occupational therapists, psychologists, social workers, pharmacist, people with a lived experience of mental illness and administration staff.

Current interventions provided by CMH services:

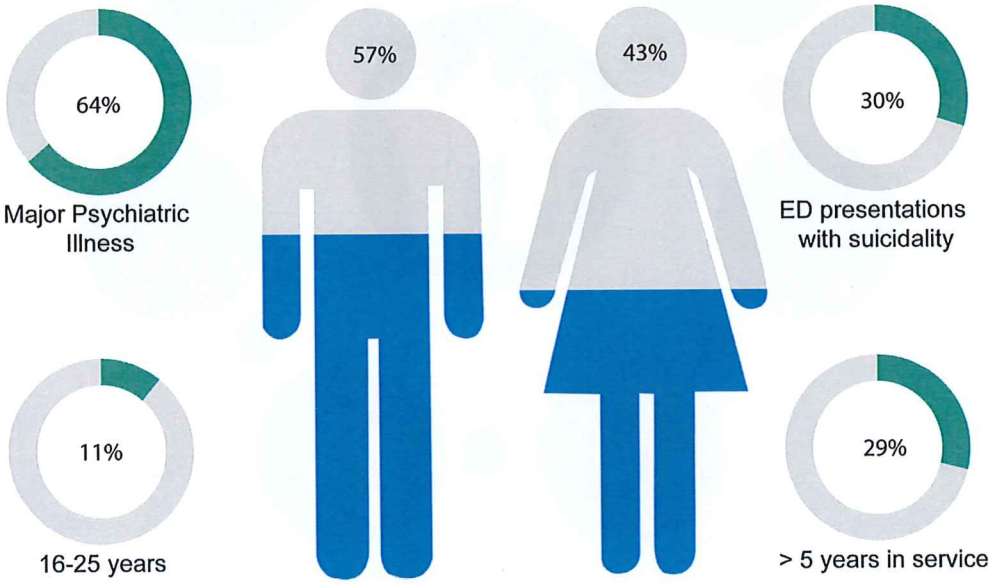


Demographics

The current CMH service population is diverse with 11% of the current community identifying English as their second language.

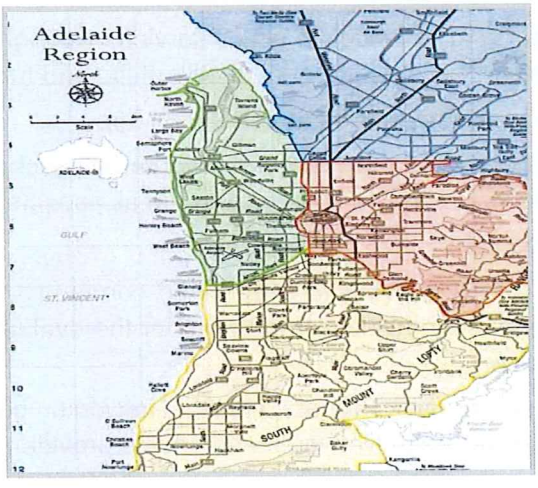
- 57 % are male and 43% female.
- 64% have a major psychiatric illness.
- 11% aged from 16 – 25 years.
- 30% of emergency department presentations have suicidal thinking.
- 29% of consumers have been in the CMH service for > 5years.

CALHN CMH population



(Sourced from CBIS, Emergency Department Data Collection and Health Information Portal. December 2018)

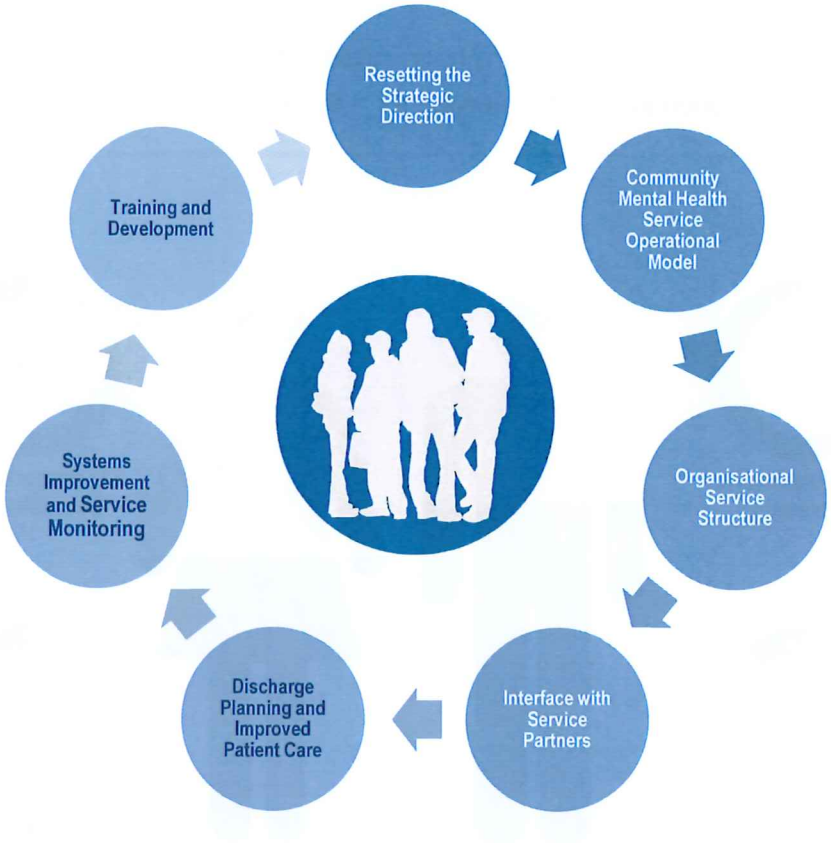
The primary catchment for CALHN CMH is the central Adelaide metropolitan region. This area spans from Outer Harbour in the north, Glenelg North in the west and as far east as Carey Gully and Athelstone.



CALHN Mental Health boundary catchment areas across metropolitan Adelaide include West and East Adelaide postcode boundaries.

Aims

The aim of the CMH model of care is to build capacity and to improve the continuity of care and effectiveness of the CALHN CMH service. The Department for Health and Wellbeing's response to the Community Mental Health Report, 2017[8] identified seven key action areas which have become the foundations for this Model of Care.



Objectives

The objectives of this CMH Model of Care are to inform a service that will:

- deliver consumer centred care. Treating people as unique individuals and not by a diagnosis. Involve consumers and carers as part of the clinical review process
- ensure that services are delivered within a safety framework
- develop a consistent approach to care service delivery across CMH services
- foster an approach to care that focuses on reducing reliance on acute services through effective and timely response, promotion of self-management and enhancement of quality of life and function
- ensure that individuals are appropriately linked with Primary Health Care providers
- develop and promote the increased utilisation and provision of recovery orientated psychological, social and therapeutic interventions across the continuum of care, including carers in all aspects of recovery
- foster opportunity for research, training and supervision
- develop a set of Key Performance Indicators (KPIs) relevant to specialised community mental health services in order to map an individual's outcomes and provide a framework for the evaluation of service quality and enhance service improvement initiatives
- build partnerships with Non-Government Organisations, Primary Health Networks, consumers and carers, General Practitioners (GPs) and other Local Health Networks and private providers.

Guiding Principles

As summarised on page 7, the CALHN CMH service has six guiding principles that define and lead how we work with our consumers, carers, our colleagues and partners in the daily delivery of mental health services every day.

1. Consumer Centred Care

The service will support consumer, carer/family engagement and collaboration in all decision making about their healthcare.

Consumer-centred care is the practice and provision of healthcare that is respectful of and responsive to the preferences, needs and values of consumers, carers and their family. It is about creating the expectation that people will be listened to and treated with dignity and compassion whilst working in partnership to design and deliver care that involves them in all decisions about their health.

Consumer's experience of CALHN CMH services should be that the:

1. Lived experience and wisdom is valued at all stages
2. Engagement between clinician and consumer is targeted around the person's strengths and capacities and that plans are created by involving the consumers.[18]

Consumer-centred care will be reflected through:

- treating consumers, carers and their families with dignity and respect
- tailoring care to suit the needs of the person and what they want to achieve
- involving, encouraging and supporting people in decision making about their mental health
- communicating and sharing information with consumers, carers and their families
- helping people find ways to get better, and remain well promoting independence.

Consumers and carers have told us that a '**good experience**' will include:

(CALHN Consumer and Carer Forum & SurveyMonkey, February 2019)

2. Evidence Based and Informed Practice

We are committed to providing safe and high-quality interventions, treatments and therapies to all consumers of CMH services. In order to achieve this, CMH services will uphold the principles of evidence-based and informed practice.[19],[20] We will focus on offering services that have demonstrated positive outcomes for consumers (through peer-reviewed research, high-impact clinical studies and meta-analyses) and deliver interventions that have maximum efficacy.

These may include:

- Pharmacological interventions
- Group therapy – structured and graded activities
- Motivational approaches
- Psychological Therapies
  - (Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy/Skills (DBT), Metacognitive Training, Mindfulness, Acceptance and Commitment Therapy (ACT))
- Hearing Voices (Maastricht) approach
- Behavioural activation
- Supportive counselling
- Peer support/lived experience approaches
- Physical health and lifestyle
- Solution focused approach
- Family and carer interventions
- Psychosocial interventions (including skills development and community interventions)
- Rehabilitation (including education and employment)
- Psychoeducation
- Sensory modulation.

We will also encourage innovations in service delivery and approaches, evaluate outcomes accordingly and continue to refine and improve our services in response to evidence-based practice.

Consumers and carers believe that all consumers will:

(*CALHN Consumer and Carer Workshop, February 2019*)

The CMH service strongly supports these values.

The range of therapeutic interventions provided should align with their unique needs and preferences. Consistent with best practice guidelines, all therapies provided should be feedback-informed involving consumers and carers in the development of care plans and giving the opportunity to collaboratively develop goals.

3. Collaborative Partnerships

Partnerships with consumers and carers is our priority.

Partnership in CMH services is about bringing together separate organisations so that they can benefit from pooled expertise, resources and influence. The aim of a partnership is to enhance the efficiency and quality of service provision for all consumers and carers through shared care and transfer of care.

There is growing evidence that improvements in health care quality and outcomes results from partnerships between health service organisations, health professionals, consumers, families, carers and communities.[21] This includes the recognition of the social inequalities of mental health, whereby the greater the inequality the higher the inequality of risk. Formal partnerships including those partnerships with a disability employment provider assist in the support for individuals with serious mental illness to find and maintain open employment.

Strong collaborative relationships and partnerships between CALHN CMH and primary health care services are critical to ensure continuity of care for all consumers and carers. CMH services have a key role in supporting the broader health system in promoting recovery and wellness.

CMH can do this by building capacity of non-government organisations and primary care providers, including GPs and private providers. There should be the ability for GPs to rapidly access CMH service expertise.

Our consumers, carers, staff and partners told us that '**future partnerships**' require:

(Quotes from Partnership and Consumer Workshops, February 2019)

Shared Care

Shared care is the preferred pathway to assist in reducing the impact of comorbid physical health issues and improve consumer's quality of life. CMH services, in a shared care arrangement, will support GPs, other providers and partner with consumers and carers through all stages of care. All multidisciplinary clinicians will strengthen partnerships with primary health care and partners.

Transfer of Care

Transfer of care from CMH service to primary care or other partners will result from a multidisciplinary clinical review. This will incorporate involvement of the consumer and carer.

Re-entry into CMH services will be facilitated by clearly defined re-entry pathways to enable smooth transition between services.

Transfer of care recognises that:

- CMH care is time limited, evidence based, recovery oriented
- a multidisciplinary clinical review, for the planning of transfer of care, will be led by a consultant psychiatrist and/or a discipline senior
- the involvement of family/carer through a face to face meeting.

A person's journey is personal and individual. When a mental health team shares this space with a person it is to assist the person and let them grow and recover.

While this journey may not be straight forward or linear, and the mental health team may move in and out of the space with the person, it is understood that relationships play a key role in recovery and are a focus of care.

4. Recovery Orientated Practice

Recovery is a process of changing attitudes, values, feelings, goals, skills and roles in life following the onset of a mental health disability or illness.[22] The CMH service facilitates consumer centred recovery by respecting and valuing the real life, unique experiences and challenges of mental health disability or illness.

We are committed to providing recovery-oriented approaches that are consumer-centred and strength-based which support people recognising and taking responsibility for their own recovery and well-being and to define their goals, wishes and aspirations.[23]

"Consumers are not defined by their illness and have hope and life goals that are more than symptom management. The capacity to be self-directed and a sense of mastery is an important aspect of wellness. Staff, carers, the consumer and their broader community play a role in holding this hope and supporting the courage and resilience recovery takes."[24]

There is now significant evidence of the impact of social, environmental and economic factors on individuals' mental health.[25] Furthermore, having a mental disorder will often result in additional health inequalities that further compound disadvantage. Mental health services have a responsibility to address the inequalities that both contribute to and result from mental disorders.[26] Inequities include social exclusion, women and gender equity and employment conditions.

This holistic approach is inclusive of the physical, emotional, psychological, functional and spiritual needs of each individual consumer and is led by a multidisciplinary team that provides a range of evidenced based skills and rehabilitative approaches.

Our consumers and carers told us that '**recovery**' allows them to:

(CALHN Consumer and Carer Workshop, February 2019)

5. Value and Develop Staff

Staff are at the foundation of how we provide safe, quality consumer centred care. Staff are fundamental to the guiding principles of recovery, collaboration, evidence and evaluation. Staff are recognised for the skills and abilities they have and will be supported to continually grow and develop in the quality of care they provide.

Services are delivered:

- within a culture of respect for one another
- within a diverse workforce
- with professional integrity
- within a safe environment.
- based on trauma informed practice.

Workloads are balanced with professional development opportunities and supervision. Practices that make a difference are recognised and celebrated across the service.

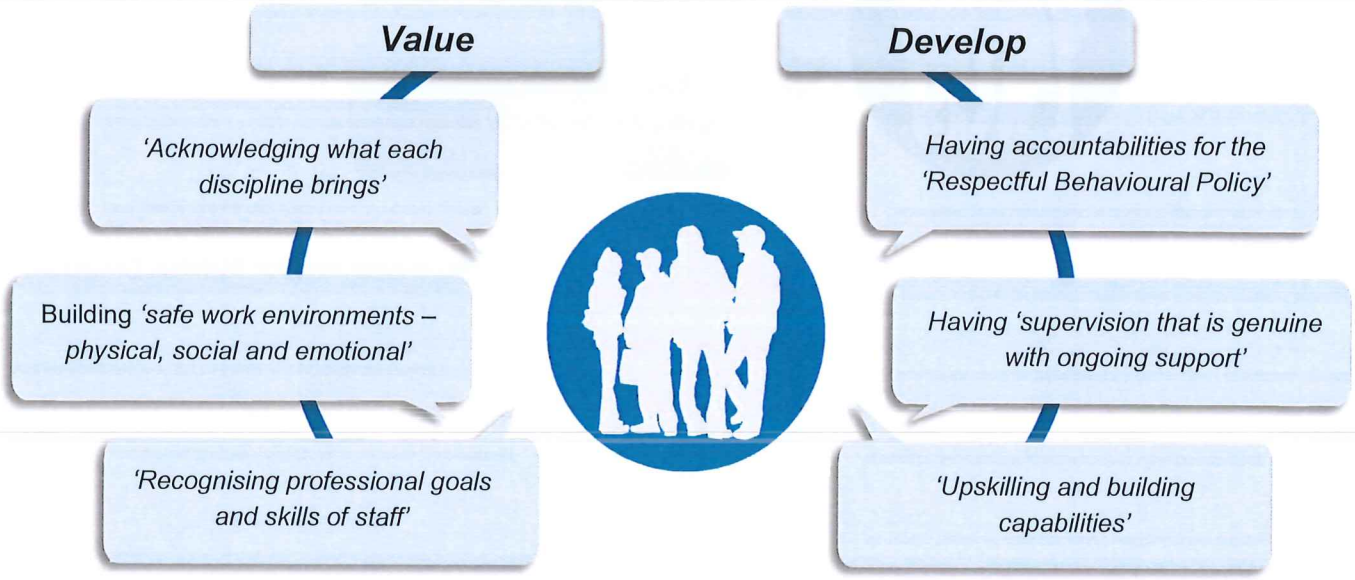
The value of multidisciplinary teams is recognised, as are the unique contributions that a diverse range of mental health staff can make to consumer care. A culture that values individuals' skills and experiences and encourages further professional development and growth, will increase staff capabilities. In turn, this will positively influence the quality of the services that are delivered.

There is a commitment to quality and safety. For the range of therapeutic interventions our services will provide, ensure and have the expectations that all clinicians are appropriately qualified, trained, supported, and experienced in order to deliver them.

Where specialised therapies and interventions are offered, we will ensure competency standards for the specific therapy have been met through comprehensive training. Performance will be evaluated, directly observed/clinically supervised (as required) and staff supported to engage in continuing professional development and clinical supervision relevant to the therapeutic interventions they are delivering.

Supervision should be competency-based, focused on the interventions / therapy and the continual development and refinement of therapeutic skills. This creates accountability for clinical governance, promotes consumer safety, and improves the quality of services provided.

Staff told us **'how to value'** and **'how to develop'** staff by:



(CALHN Staff Workshop 4, March 2019)

In order to provide the tertiary-level CMH service that meets our consumers' and carers' needs, staff will be encouraged to work to full scope of practice, and we will provide opportunities for them to do so. With a culture of reflective-practice, staff will be encouraged to engage in ongoing learning from their experiences with consumers and carers (including integrating feedback from consumers and carers), and to always aspire to continually improve practice.

6. Outcomes and Evaluation

In seeking to deliver the highest standard of care, formal and informal, quantitative and qualitative evaluation and review of the CALHN CMH service will be undertaken.

CALHN CMH will regularly seek the input from our consumers and carers through experience of care surveys and dedicated consumer and carers groups, forums and workshops. The consumer and carer feedback will enable the CMH services to evaluate, reflect and continuously improve the delivery of consumer centred care to ensure that it aligns with consumer and carer needs.

CALHN CMH services will regularly seek feedback from partners on the current status of relationships to further develop and improve shared care, transfer of care, referral and re-entry service management.

There are a number of national agreed clinical performance measures and data collections that support service outcomes and evaluation. These include the National Mental Health Key Performance Indicators[27], Fifth Mental Health & Suicide Prevention Plan[1] indicators and collections such as the National Outcomes and Casemix Collection (NOCC).

Elements of this collection include:

- Health and National Outcome Scales (HoNOS)
- Life Skills Profile 16 (LSP-16)
- Kessler 10+ (K 10+)
- Phases of Care
- Principal diagnosis.

These measures will be used to evaluate consumer progress and care requirements over time.

From a consumer experience perspective the Your Experience of Service (YES) Survey is identified within the Fifth Plan as a key informer of service experience feedback. The Carer Experience of Service (CES) also needs to be considered to ensure we evaluate carer perceptions.

Activity trend data would include the:

- number of registered consumers
- number of consumers who have had a transfer of care from CMH (discharges)
- percentage of readmissions within six months
- emergency department presentations for registered consumers.

CALHN CMH services will participate in accreditation programs. Training programs will enable staff across all levels of CMH to understand and interpret KPIs and utilise them in the delivery of daily care for improved consumer outcomes.

Core Business

It is recognised that a mental illness covers a broad spectrum of disorders, most of which are well managed by primary and secondary health services. The CMH service recognises that all people experience heightened levels of distress at times, that this is part of the normal range of human emotional experience, and that in many cases, this will resolve without the need for additional intervention. The service will seek to balance providing support to people with significant psychological distress, whilst taking care to not 'medicalise' these normal human experiences.

As a tertiary specialist service, CALHN CMH service provides care for people living in the CALHN CMH catchment area. The specialist mental health expertise or 'core business' that CALHN CMH will provide includes the following:

- *Persons aged 16 – 65 years.*
- *Major psychiatric illness.*
- *Mental health crisis.*
- *Responding to suicidal individuals.*
- *Borderline Personality Disorder.*
- *Mental illness complicated by substance misuse.*
- *Other comorbid conditions with the above.*

As a tertiary mental health service, CALHN CMH service aims to also assist primary and secondary health services to assess and manage the above condition within the community. A major psychiatric illness is characterised by significant disturbance in a person's thought processes, emotional reactions, perceptions or behaviours due to a disruption of the biological, psychological, or developmental processes underlying mental functioning. This is clearly demonstrated by deterioration in social, occupational, or other important activities.

When referrals are received for people outside of the core business criteria, and if there are more appropriate and less restrictive services available to provide care within other health services, CALHN CMH services will engage with other service providers in the development of collaborative pathways to enable referral to the appropriate service provider.

Other conditions outside of 'core business and which may be managed by other specialist services include:

- *Drug and alcohol conditions.*
- *Intellectual disability.*
- *Attention Deficit Hyperactivity Disorder.*
- *Autism spectrum disorders.*
- *Acquired brain injury.*
- *Dementia.*

Referral pathways will be developed in collaboration with external providers and primary care to ensure that referred consumers and their carers who do not have an underlying mental health illness, will not be delayed in their referral to appropriate services. Staff will approach non-core referrals with respect and proactively enable referrals to correct services outside of CMH services.

Acute Care Functions

The primary focus of Acute Care functions in CMH is to provide assessment and intervention for consumers in the acute stages of mental illness. The primary goal is the short term reduction in severity of symptoms and distress.

These functions are delivered by a multidisciplinary team and will aim to address the intensity of symptoms for the consumer and support the management of risk associated with the illness.

Acute functions are designed to be dynamic and responsive to individual consumer's mental health needs.

CMH services liaise closely with other inpatient, non-government organisations and primary health services to ensure access to a range of supports for the benefit of the consumer.

Key functions would include:

- timely responses to referrals for consumers
- working in partnership with the consumer and other identified partners to deliver specialised mental health services as an alternative option to a hospital admission
- biopsychosocial specialist assessment, including risk mitigation
- short term therapeutic interventions for people presenting with a:
  - mental illness or psychological crisis and/or suicidal ideation, or
  - significant degree of impact on the person's ability to function safely in the community, who might otherwise require admission to hospital
- facilitating transfer of care to the most appropriate service, in the least restrictive environment, at the earliest opportunity.

Ongoing Care Functions

The Ongoing Care function is designed to provide specialised care that continues beyond the recovery from an acute episode of illness. These services are delivered by a specialised mulitdisciplinary team with the primary goal to:

- reducing the severity of mental health symptoms whilst strengthening psychosocial function, living skills and community participation
- preventing relapse
- hospital avoidance
- risk management.

Ongoing Care focuses on improving function, consolidating gains and/or providing intensive extended care within a time limited period. It involves collaborative use of partnerships with the consumer, their familes and friends, primary health care, GPs, acute and emergency services, non-government organisations and other relevant community agencies, with a clear exit pathway from CMH services.

This is achieved through provision of care that is trauma informed, recovery orientated, strengths and evidenced based, consumer centred and with identified processes and evaluation points. Delivery of treatment and care will be consistent and assertive depending on the identified needs of the consumer within the stage of care.

Key functions would include:

- coordination and liaison
- rehabilitation
- medication clinics and clinic services
- case review
- evaluation.

Priority Areas

Suicide Response

Preventing suicide is an agreed national policy priority requiring a co-ordinated approach across all levels of government. This includes:

- the Commonwealth Government funding health and suicide prevention services through the Primary Health Network and national non-government services
- South Australian Suicide Prevention Plan (2017 – 2021)[14] outlines the state government priorities.

Despite ongoing work to improve suicide prevention efforts in Australia, there has been no significant reduction in the suicide rate during the last decade. [28]

In 2017 *the Australian Bureau of Statistics*[28] reported that:

- 3,128 people died from suicide, 12.6 deaths per 100,000 persons.[14, 28]
- Suicide ranked as the 2nd leading cause of death for Indigenous males, with 39.6 deaths per 100,000 persons and 7th for Indigenous females, at 11.9 deaths per 100,000 persons. [28]
- For the Non-Indigenous population, suicide ranked as the 10th and 21st leading cause for males and females, respectively.[28]
- *In South Australia, there was a decrease in suicide rates from 13.3 (per 100,000) in 2016 to 12.8 (per 100,000) in 2017.*[14]

The causes of suicide and suicide attempts can be complex and multifaceted. While some mental illnesses are linked to an increased risk of suicide, not everyone who dies by suicide will have a mental illness.

It has long been recognised that people who suicide have become disconnected from others. A consistent message from people with a lived experience of suicide is that feeling connected and worthwhile is vital in reducing the risk of suicide and for this reason it is important that people are at the centre of the suicide prevention and response plan.

In CALHN Mental Health, we have adopted a best practice approach known as '*Connecting with People'*, that provides a more comprehensive approach to suicide mitigation. The 'Connecting with People' program is required under the South Australian Suicide Prevention Plan and we have commenced training of our mental health clinicians and targeted Emergency Department staff. The 'Connecting with People' program provides a common and consistent framework across the state.

At the heart of 'Connecting with People' is a paradigm shift in thinking about suicide:

- From risk assessment
- To comprehensive planning, and
- Suicide mitigation.

The program recognises the protective factors and the changeable nature of suicidal thought and intent. This benefits not only the person at risk of suicide, but also assists professional to accept the limitations of a paternalistic approach instead work to increase the person's own resilience and resourcefulness.

Trauma Informed Care and Practice

Trauma is defined as an event, series of events or set of circumstances that are experienced as physically or emotionally harmful or life threatening. There is a wide range of events that can potentially cause trauma such as abuse, loss and other chronic stressors including poverty, racism and historical trauma.

Childhood trauma is the single most significant predictor that an individual will have contact with the mental health system. Trauma can result in acute and/or ongoing adverse effects, distress or disruption towards an individual's functioning, mental, physical, social, emotional and spiritual wellbeing.[29]

Trauma informed care and practice recognises the link between trauma and mental health problems and the high prevalence of traumatic life experiences suffered by many of the people seen by mental health services.[30]

Trauma informed care is an integral part of recovery oriented practices which clearly articulates 'that no one understands the challenges of the recovery journey from trauma better than the person living it'. CALHN CMH services is committed to the training of staff in trauma informed care, delivering 'evidence based models' and to incorporate the principles of safety, trustworthiness, choice, collaboration and empowerment. Least restrictive practices, as supported by the *Mental Health Act 2009* (SA), form an essential foundation to a trauma informed approach and have been accepted both internationally and nationally as best practice.[31]

Youth Mental Health

Half of all lifetime cases of mental health disorders start by age 14 years and three fourths by age 24 years.[32]

CALHN CMH services will provide a youth specific specialist community mental health service to individuals aged 16 – 25 years. The service targets consumers who are experiencing mental health issues which have not been able to be addressed by Tier 1 (primary care) or Tier 2 (specialist care with mental health expertise) services. This will be delivered by a multidisciplinary team, in partnership with other health care services.

Youth Mental Health Services are designed to successfully engage and be responsive to the consumer's developmental stage and mental health needs.

Key features of the youth services include:

- early intervention aimed at developing therapeutic rapport and reducing distressing symptoms as quickly as possible
- engagement with consumer and significant others to provide education, support and develop a care plan
- ensuring continuity of care upon discharge or transfer of care.

Physical and Mental Health

A distinction is often made between 'mind' and 'body'. In the management of consumers with a mental health illness or disability, mental and physical health should not be separated. Poor physical health can lead to an increased risk of developing mental health problems. Similarly, poor mental health can negatively impact on physical health, leading to an increased risk of comorbidity factors and reducing their life span by 10 – 20 years.[33]

Both internationally and nationally, there is substantial evidence that the risk factors for chronic physical disease are higher in people living with severe and persistent mental illness than that of the general population. The association between mental illness and poor physical health is well established.[34]

- People with schizophrenia are 2.5 times more likely to have diabetes compared with the general population. [35]
- High rates of diabetes and cardiovascular disease are more likely in people with:
  - a bipolar disorder
  - depression
  - or other mental disorders including post-traumatic stress disorder.[36]
- Rates up to 60% of diabetes and cardiovascular disease are seen in people with psychosis with a longer duration of illness and use of antipsychotic medication.[37]

Our consumers told us that '**recovery included**':

(CALHN Consumer and Carer Workshop, February 2019)

CALHN CMH services recognises that risk factor screening and the management and regular monitoring of both mental health conditions and comorbid risk factors are critical to the holistic approach in mental health recovery. Shared-care partnerships with primary health services are critical to the overall management of our consumers to provide care that incorporates both their mental and physical health.

Responsive to Diversity

Aboriginal People

The Aboriginal concept of health is holistic and encompasses mental health, physical, cultural and spiritual health and is often referred to as social and emotional wellbeing. This holistic concept recognises that connection to land, culture, spirituality, family, social, economic, political, and ideological and community are important to Aboriginal peoples and impacts on their wellbeing. Disruption in the harmony of these interrelations results in ill health for the individual and impacts on their supports and the wider Aboriginal community. [38, 39,40,41]

(Social and Emotional Wellbeing Aboriginal Perspective on Health Sourced Purdie N, Dudgeon P, Walker R. 2010)

Approximately 9% of Aboriginal people access mental health services in South Australia.[42] Approximately 7% access mental health in the CALHN CMH service. A significant number of Aboriginal people who access CALHN Mental Health Services are from outside of CALHN catchment area, including rural and remote areas of South Australia and from interstate.[43]

As a service, we need to consider the individual context of our consumers' presentations and the social determinants that affect them. Racism, stigma, environmental adversity, social disadvantage and culturally unsafe services culminate in continued stressors for Aboriginal people and negatively impacts on their mental health and wellbeing. [44,45,46]

It should be recognised that consumer centred, trauma-informed care is paramount to delivering a service that is relevant, respectful and timely.

Our mental health service needs to be culturally responsive and flexible as well as have the ability to collaboratively work, closely and in partnership, with the consumer, their support network, other services and healthcare providers towards recovery and rehabilitation.[38,40,44] To achieve this, cultural education to all staff, increase in employment of Aboriginal and culturally sensitive non-Aboriginal practitioners and work in partnership with the local communities is required. [38,39,40]

Culturally and Linguistically Diverse

The term 'Culturally and Linguistically Diverse' (CALD) describes those people who were either born overseas or had a parent born overseas and originating from non-English speaking countries. According to 2016 'Census of Population and Housing' data (Australian Bureau of Statistics), 49% of Australia's population were either born overseas or had a parent born overseas.

CALD populations may include those who have had a positive experience of immigration to Australia; or those such as refugee populations, whose experience of immigration may have been fraught with challenges, grief and trauma.

The biggest obstacles faced by CALD consumers in addressing health and mental health care needs are:

- access to services - with communication challenges, lack of accessible education and presence of cultural differences[47]
- transcultural challenges especially in language with variable commonality of terminology, translation and interpretation
- stigma and the associated concerns that include cultural perspectives of mental illness
- psychosocial stressors such as 'poverty, immigration, violence, racism and discrimination.[48]

There are significant differences between migrants, refugees and asylum seekers; this includes both pre and post migration experiences. These experiences impact on health and health care.

The refugee experience is one of loss, trauma, violence and dislocation, with variable access to health care, nutrition, safety, and schooling in transit countries. Settlement in a new country also brings stressors; navigating the health system, housing school and work access, often compounded by ongoing fear and concern for family left behind.

For asylum seekers there is the added mental health impact of imposed and punitive conditions of adversity, detention, insecure residency, and restricted access to financial support, work and study. This is quite different from the generic experience of migrants.

The experiences of refugees / asylum seekers impact on prevalence of psychological disorders as well as health care in respect to illness presentation and management. Cultural competency and safety is paramount in:

- understanding the individual's cultural context
- understanding the cultural barriers for seeking mental health assistance
- engaging interpreters, with consideration to gender, ethnic and cultural background of the interpreter is fundamental.

Developing partnerships with families, CALD communities, GPs and other service providers are key to improving access, education and advocacy for CALD consumers.

CMH services aim to develop sound knowledge and understanding of relevant experiences of particular CALD population groups related to 'torture, trauma, displacement and loss'.[48] Culturally sensitive practice approaches and trauma-informed care are essential foundations in the delivery of transcultural practice.

Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI+)

Since August 2013, the Sex Discrimination Act 1984 has provided federal protection for both indirect and direct discrimination on the basis of sexual orientation, relationship status, gender identity and intersex status.[49]

The majority of LGBTQI+ people lead happy, healthy and fulfilling lives.[50] However, compared to the general population, LGBTQI+ people have an increased risk of depression and anxiety, self-harming and are more likely to attempt suicide in their lifetime.

It is recognised that many LGBTQI+ people are adversely affected by multilayered discrimination, marginalisation and stigma.[51] CALHN CMH services will develop and maintain strong relationships with relevant community and support groups and recognise the skills and understanding of staff to enable them to effectively work with individuals who identify as LGBTI+ and their carers.

We will build staff's competence in diversity, including soft skills, use of gender neutral language and specific LGBTQI+ knowledge will provide a responsive and inclusive service for the LGBTQI+ community. This includes the understanding and recognition of LGBTQI+ peoples' sexual orientation, sex and/or gender identity.

Homelessness

Homelessness currently affects 5985 people in South Australia, with the highest percentage (18%) aged between 25 – 34 years. The highest contributor of homelessness at 42% is 'accommodation issues' that includes inadequate housing or unsatisfactory dwellings, followed by 'Domestic and relationship issues' at 33%.[52] Statistically, there is a high prevalence of mental health disorders affecting those faced with homelessness[53], whether these be contributory to or resultant from homelessness.

Geographically, the CALHN catchment area covers the Central Business District (CBD) including the parklands. A significant proportion of homelessness and emergency support services are based within the CBD and fringe suburbs including the Vincentian Centre, Catherine House Programs and Hutt Street Centre. Boarding houses, supported residential facilities, drug and alcohol facilities and other transient accommodation options are also situated throughout the broader catchment area.

The role of the tertiary CMH service is one of advocacy, partnership and liaison.

Workforce

There are currently four multidisciplinary teams in CALHN CMH services including Glynburn, Hallett, Port and West teams. Each multidisciplinary team includes:

- Administration
- Allied Health
- Lived Experience Workforce
- Medical
- Nursing.

Workforce configuration is out of scope of the CALHN CMH Model of Care. Workforce requirements will be considered following mapping of current and future clinical pathways and establishment of clinical workloads.

Glossary

Term	Definition
Acquired brain injury	Any type of brain damage that happens after birth. Causes include disease, stroke, blows to the head, alcohol and drug use, or oxygen deprivation.
Acute care	The provision of assessment and intervention for consumers in the acute stages of mental illness with a short term goal of the reduction in severity of symptoms and distress.
Community mental health services	Provision of specialist tertiary mental health services to persons aged 16 – 65 years with underlying psychiatric illness.
Attention Deficit Hyperactivity Disorder (ADHD)	ADHD is a chronic condition marked by persistent inattention, hyperactivity, and sometimes impulsivity. ADHD begins in childhood and often lasts into adulthood..
Autism spectrum disorders	Autism spectrum disorders are lifelong developmental disabilities characterised by marked difficulties in social interaction and social communication, and restricted and repetitive interests and behaviours.
Borderline Personality Disorder (BPD)	BPD is a mental illness that makes it difficult for people to feel safe in their relationships with other people, to have healthy thoughts and beliefs about themselves and to manage their emotions and impulses. People living with BPD may experience distress in their work, family and social life, with increased risk of suicide and self-harm. BPD can have a significant impact on friends, families and carers.
Collaborative partnerships	Bringing together separate organisations so they can benefit from pooled expertise, resources and influence.
Comorbidity	Comorbidity simply means the co-occurrence of one or more diseases or disorders in an individual. Comorbidity also implies interactions between the illnesses that can worsen the course of both.
Consumer centred care	The practice and provision of healthcare that is respectful of and responsive to the preferences, needs and values of consumers, carers and their family. It is about creating the expectation that people will be listened to and treated with dignity and compassion whilst working in partnership to design and deliver care that involves them in all decision about their health.
Continuity of care	Continuity of care is a concept relevant to all stages of a consumer's pathway and includes aspects of coordination, access to services and the availability of services. Continuity relies on the development of good relationships and trust with health care professionals.
Culturally and Linguistically Diverse (CALD)	The term CALD describes those people who were either born overseas or had a parent born overseas and originating from non-English speaking countries.
Dementia	A term used to describe the symptoms of a number of neurological conditions that lead to the decline in mental abilities across a range of cognitive functions severely enough to interfere with daily life.
Individual Placement and Support (IPS) Program	A formal partnership between CALHN Community Mental Health and a Disability Employment Services (DES) provider. The partnership aim is to provide support for individuals with a serious mental illness to find and maintain open employment.
Intellectual disability	Intellectual disability is a disability characterised by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behaviour, which covers a range of everyday social and practical skills.

Term	Definition
Key performance Indicators (KPIs)	KPIs are a quantifiable measures used to evaluate the success of a project, activity, therapy, organisation, employee etc., in meeting objectives for performance.
Major psychiatric illness	A major psychiatric illness is characterised by significant disturbance in a person's thought process, emotional reactions, perceptions or behaviours due to a disruption of the biological, psychological, or developmental processes underlying mental functioning. This is clearly demonstrated by deterioration in social, occupational, or other important activities.
Mental health crisis	A mental health crisis is a non-life threatening situation where a person is exhibiting emotional distress or behavioural disturbance that may compromise their ability to function.
Multidisciplinary team	Services / treatment is offered by a team of staff including medical officers, nurses, occupational therapists, psychologists, social workers, people with a lived experience of mental illness and administration staff.
National Outcomes and Casemix Collection	National Outcomes and Casemix Collection (NOCC) comprises a range of clinician and consumer rated measures. NOCC measures whether a change has occurred for a consumer as a result of mental health care.
Ongoing care	The provision of specialised care that continues beyond the recovery from an acute episode of illness.
Pharmacological interventions	Using pharmaceutical drugs in the treatment of people with a mental illness.
Primary care	Mental health services and support which are embedded into primary care such as GPs, community pharmacists and practice nurses - who provide holistic care.
Primary Health Care	Entry level to the health system and as such is usually a person's first encounter with the health system. It includes a range of activities and services from health promotion and prevention, to treatment and management of acute and chronic conditions.
Psychoeducation	An evidence-based therapeutic intervention to consumers, their carers and families that provide information and support to better understand and copy with illness.
Recovery	Recovery is a process of changing attitudes, values, feelings, goals, skills and roles in life following the onset of a mental health disability or illness.19
Shared care	In a shared care arrangement, community mental health services will support general practitioners and other providers, and partner with consumers and carers through all stages of care.
Tertiary care	Specialist mental health care provided in the community and hospital.
Therapeutic intervention	A therapeutic intervention is a particular evidence-based technique, skill, or treatment implemented to facilitate positive therapeutic change with a consumer.
Transfer of care	Transferring care from one service to another as a result of a clinical review involving the consumer and carer.
Trauma	Defined as an event, series of events or set of circumstances that are experienced as physically or emotionally harmful or life threatening; such as abuse, loss and other chronic stressors including poverty, racism and historical trauma.
Trauma informed care and practice	Trauma informed care and practice recognises the link between trauma and mental health problems and the high prevalence of traumatic life experiences suffered by many of the people seen by mental health services.[24]
Youth services	Community mental health services to persons aged 16 – 25 years with existing or emerging mental health issues.

References

[1] **The Fifth National Mental Health and Suicide Prevention Plan**. National Mental 2017. http://www.mentalhealthcommission.gov.au/our-reports/fifth-national-mental-health-and-suicide-prevention-plan.aspx

[2] Health Consumers and Carers Alliance of SA Inc. **What is Consumer Centred Care?** .https://www.hcasa.asn.au/service-providers/consumer-centred-care

[3] **Stepping up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012**. South Australian Social Inclusion Board. https://www.sahealth.sa.gov.au/wps/wcm/connect/8ea68b804308c5cfb076fa2cf7cfa853/steppingupmentalhlthreform0712-socinclusion-2010.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8ea68b804308c5cfb076fa2cf7cfa853-lZHlThs

[4] **A review of Community Mental Health Services in South Australia.** South Australia Social Inclusion Board, V7.0, 8th January 2008. https://www.sahealth.sa.gov.au/wps/wcm/connect/2aa76200450cdab791e2d3cfa5ded0ab/CMH+Review+2008.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-2aa76200450cdab791e2d3cfa5ded0ab-llTzAfw

[5] **Adult Community Mental Health Services (Metropolitan Regions). Model of Care**. 9th April 2010. Government of South Australia. https://www.sahealth.sa.gov.au/wps/wcm/connect/adc473804308ca3cb0e1fa2cf7cfa853/ModelofCareAdultComm-MHU-100414.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-adc473804308ca3cb0e1fa2cf7cfa853-lPTsRLG

[6] **Mental Health: Exploring Collaborative Community Reform in South Australia**. A research report prepared by the Australian Centre for Community Services Research, Flinders University, supported by the Mental Health Coalition if South Australia and the Don Dunstan Foundation. February 2016. https://www.dunstan.org.au/docs/2016-Community-Mental-Health-Full-Report.pdf

[7] **Community Mental Health report A report from the Implementation Partner**, Deloitte 13 July 2015. http://www.cpsu.asn.au/upload/2016-Info-Updates/20160713-SA-Health-Comm-MH-Report-FINAL.PDF

[8] **Department for Health and Wellbeing. Response to the Community Mental Health Report**. March 2017. http://inside.sahealth.sa.gov.au/wps/wcm/connect/f29cf9804068f81fa8f8ebdeb8488407/Comunity+Mental+Health+Review+Response+Finalv3.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-f29cf9804068f81fa8f8ebdeb8488407-m8CAkN8

[9] **The National Mental Health Service Planning Framework**. 2019. https://nmhspf.org.au/

[10] **Sa Health Strategic Plan 2017 to 2020**. Sa Health. Government of South Australia. https://www.sahealth.sa.gov.au/wps/wcm/connect/bcf7e404-2c3a-4158-b688-c9f6129c09c2/17075.5%2B-%2BSAHSP_Report%28interactive%29WS.PDF?MOD=AJPERES&CACHEID=ROOTWORKSPACE-bcf7e404-2c3a-4158-b688-c9f6129c09c2-mAT94X7

[11] **South Australian Mental Health Strategic Plan**. 2017-2020. SA Mental Health Commission. Government of South Australia. https://samentalhealthcommission.com.au/wp-content/uploads/SA-Mental-Health-Strategic-Plan-2017%E2%80%932022.pdf

[12] **National Safety and Quality Health Standards (NSQHS)**- second edition. November 2017. Australian Commission. https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/

[13] **South Australian Mental Health Act 2009**. Government of South Australia. https://www.legislation.sa.gov.au/LZ/V/A/2009/MENTAL%20HEALTH%20ACT%202009_28.aspx

[14] **South Australian. Suicide Prevention Plan** (2017-2021). Government of South Australia. SA Health. https://www.sahealth.sa.gov.au/wps/wcm/connect/89cf2e8040a76656898cfb2559774525/South+Australian+Suicide+Prevention+Plan_June+2018_Final.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-89cf2e8040a76656898cfb2559774525-meKjhpf

[15] Pathways to Care Policy Directive 2014. Sa Health. https://www.google.com/search?q=PAthways+to+care+policy+directives+2014&rlz=1C1GCEA_enAU823AU823&oq=PAthways+to+care+policy+directives+2014&aqs=chrome..69i57.8543j0j8&sourceid=chrome&ie=UTF-8

[16] **South Australian Carers Act 2005.** https://www.legislation.sa.gov.au/LZ/C/A/CARERS%20RECOGNITION%20ACT%202005.aspx

[17] **Central Adelaide Local Health Network. 2017-2018 Annual Report**. September 2018. https://www.sahealth.sa.gov.au/wps/wcm/connect/937a1074-11a2-43f7-b744-a89cf1773aa3/Annual+Report+2017-2018+CALHN+FINAL+MIN+REVIEW.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-937a1074-11a2-43f7-b744-a89cf1773aa3-mASf1oA

[18] **Strengths Model: A Recovery-Oriented Approach to Mental Health Services Core Training Manual** October 2013 Version Reviewed June 2014.

[19] SA Health (2012). **The Framework for Recovery-Orientated Rehabilitation in Mental Health Care.** Mental Health & Substance Abuse Division.

[20] **Commonwealth of Australia (2013). A National Framework for Recovery-Orientated Mental Health Services: Guide for Practitioners and** Providers. Australian Health Ministers' Advisory Council, National Mental Health Strategy.

[21] **National Safety and Quality Health Service Standards**, op cit, p23.

[22] Anthony W,1993 **Towards a Vision of Recovery**, Centre for Psychiatric Rehabilitation.

[23] Commonwealth of Australia. 2013. **A national framework for recovery-oriented mental health services: Guide for Practitioners and providers, Canberra, Commonwealth of Australia.**

[24] Glover, H. **Unpacking Practices That Support Personal Efforts Of "Recovery "A resource book for workers and practitioners within the mental health sector**. 2010. http://southmetropolitan.health.wa.gov.au/Utilities/BinaryDownload.aspx?BinaryField=DocumentBinary&BinaryTable=TBLEDCMSDOCUMENTS&BinaryID=DOCUMENTID&BinaryIDValue=57145

[25] World Health Organization and Calouste Gulbenkian Foundation. **Social determinants of mental health**. Geneva, World Health Organization, 2014

[26] Campion, J., Bhugra, D., Bailey, S., Marmot, M. (2013). **Inequality and mental disorders: opportunities for action.** The Lancet, Volume 382, (9888): 183 – 184.

[27] **Key Performance Indicators for Australian Mental Health Services**. Third Edition.2013. National Mental Health Strategy. Australian Institute Health and Welfare. https://www.aihw.gov.au/getmedia/f9bb1a07-a43b-458a-9b73-64ef19d8aedd/Key-Performance-Indicators-for-Australian-Public-Mental-Health-Services-Third-Edition.pdf.aspx

[28] Australian Bureau of Statistics. 3303.0 – Causes of Death, Australia, 2017. https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3

[29] NSW Government, **Trauma-Informed Care and Practice in Mental Health Services**. https://www.aci.health.nsw.gov.au/networks/mental-health/trauma-informed-care-and-practice-in-mental-health-services

[30] NSW Government. **South Eastern Sydney Local Health District, Mental Health Service. Rehabilitation Model of Care** 2016.

[31] Kezelman C, Stavropoulos P. **Practice Guidelines for Treatment of Complex Trauma and Trauma informed Care and Service Delivery.** 2012. Blue Knot Foundation.

[32] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR & Walters EE (2005). **Lifetime prevalence and age of onset distributions of DSM-IV Disorders in the National Comorbidity Survey replication**. Archives of General Psychiatry, 62, p 593.

[33] World Health Organisation. **Management of physical health conditions in adults with severe mental disorders**. https://apps.who.int/iris/bitstream/handle/10665/275718/9789241550383-eng.pdf

[34] Holt RIG, Mitchell AJ. **Diabetes mellitus and severe mental illness: mechanisms and clinical implications**. Nature Reviews Endocrinology. 2015;11(2):79-89.

[35] Stubbs B, Vancampfort D, De Hert M, Mitchell AJ. **The prevalence and predictors of type two diabetes mellitus in people with schizophrenia: a systematic review and comparative meta-analysis**. Acta Psychiatrica Scandinavica. 2015;132(2):144-157.

[36] Rosenbaum S, Stubbs B, Ward PB, Steel Z, Lederman O, Vancampfort D. **The prevalence and risk of metabolic syndrome and its components among people with post-traumatic stress disorder: A systematic review and meta-analysis. Metabolism Clinical & Experimental**. Aug 2015;64(8):926-923.

[37] Vancampfort D, Stubbs B, Mitchell AJ, et al. **Risk of metabolic syndrome and its components in people with schizophrenia and related psychotic disorders, bipolar disorder and major depressive disorder: a systematic review and meta-analysis**. World Psychiatry. 2015;14(3):339-347.

[38] Purdie, Nola; Dudgeon, Pat; and Walker, Roz, "**Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice** (First Edition)" (2010).

[39] Aboriginal Health Council, 2015, **Rising Spirits Community Resilience Project: Final research report** , May 2015.

[40] Central Adelaide Local Health Network: Mental Health Directorate, 2017, **Aboriginal Mental Health Clinical Practice Guideline and Pathways: A culturally appropriate guide to working with Aboriginal mental health consumers**, 2017: SA Health.

[41] Australian Indigenous HealthInfoNet. **Social and Emotional Wellbeing**. Perth: Australian Indigenous HealthInfoNet, 2019.

[42] **Summary Report: Statewide Aboriginal Mental Health Consultation, July 2010** (South Australian Government).

[43] Central Adelaide Local Health Network, 2014, **Aboriginal Health Improvement Plan 2014-2016**, South Australian Government.

[44] **National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2004-2009**, Department of Health: Implementation plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 2015.

[45] Australian Indigenous HealthInfoNet. **Overview of Australian Indigenous and Torres Strait Islander health** status. Perth: Australian Indigenous HealthInfoNet, 2019.

[46] National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners, 2018, **National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people**. 3rd edn. East Melbourne, Vic: RACGP, 2018.

[47] **Enhancing Family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia**, AFRC Issues No.3 June 2008, Australian Institute of Family Studies, Australian Government, 2008.

[48] **Pathways of Recovery: Preventing further episodes of mental Illness: People from culturally and linguistically diverse backgrounds**, D. Rickwood, Commonwealth of Australia, 2006.

[49] National LGBTI Health Alliance. https://lgbtihealth.org.au/lgbti/

[50] Beyond Blue. https://www.beyondblue.org.au/who-does-it-affect/lesbian-gay-bi-trans-and-intersex-lgbti-people/factors-affecting-lgbti-people

[51] Australian Government. Department of Health. **A National Framework for recovery-orientated mental health services: Guide for practitioners and providers**. http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-10~mental-pubs-n-recovgde-10-les

[52] **Homelessness in South Australia**, Homelessness Australia: Creating a framework for ending homelessness, Australia Bureau of Statistics, Census of Population and Housing: Estimating Homelessness, 2012.

[53] **Mental Health, Housing and Homelessness in Australia**, Mental Health Council of Australia, 2012.

For more information

Mental Health Directorate
Glenside Health Services
226 Fullarton Road
GLENSIDE SA 5065
Telephone: 7087 1000
www.sahealth.sa.gov.au