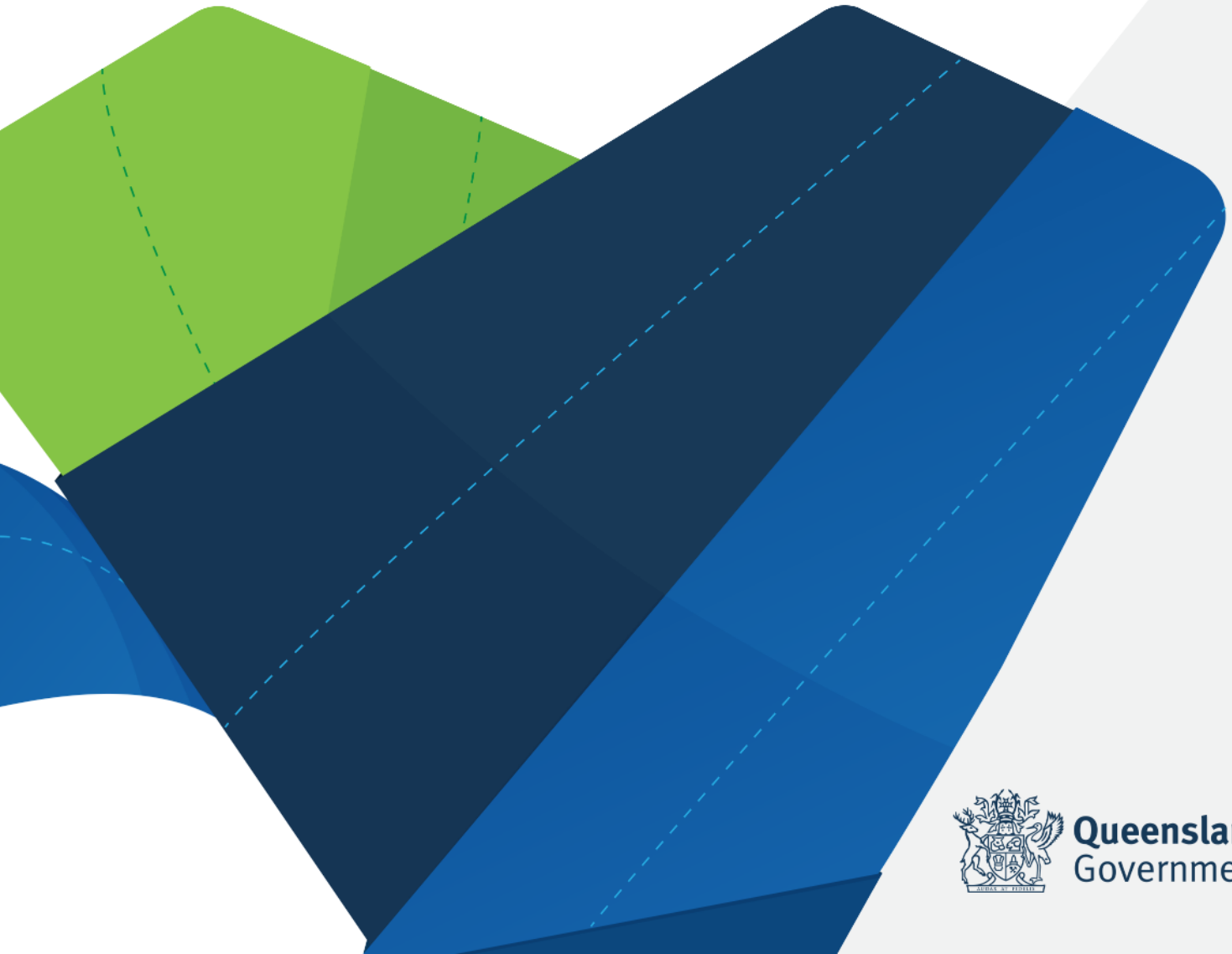
Referring for Community Support Activities in Mental Health (RCSAiMH) Project

Final Evaluation August 2021



Queensland Government

Referring for Community Support Activities in Mental Health (RCSAiMH) Project - Final Evaluation

Published by the State of Queensland (Queensland Health), SELECT DATE

For more information contact:

Allied Health Professions' Office of Queensland, Queensland Health, GPO Box 48, Brisbane QLD 4001,
email email@health.qld.gov.au, phone (07) 3328 9310.

An electronic version of this document is available at www.insert.website.here.com

Final Report prepared by:

Tom Meehan & Yolanda Mansfield
Service Evaluation and Research Unit (SERU)
Mental Health & Specialised Services
The Park Centre for Mental Health
West Moreton Health

Acknowledgements

The authors would like to acknowledge and thank the staff from the respective Queensland Health and Community Managed Organisations who gave their time to participate in the evaluation.

Contents

Executive Summary

Background

The emphasis on consumer-centred Recovery in the mental health field in Australia and overseas has led to significant changes in the way in which care is provided to those with psychiatric disability. In Queensland, Mental Health Alcohol and Other Drugs (MHAOD) services are increasingly entering into service level agreements with Community Managed Organisations (CMOs) to provide a range of psychosocial support services to complement those provided by clinical mental health services. A key factor in the success of this reform agenda is the redistribution of work between mental health staff (i.e., AHPs) and psychosocial support workers. One initiative established in 2019 to facilitate this process was the 'Referring for a Community Support Activity in Mental Health' (RCSAiMH) Project. This initiative, developed through the Allied Health Professions Office of Queensland (AHPOQ), was designed to improve the way in which referral processes for psychosocial support between Queensland Health (QH) and respective Community Managed Organisations partner organisations are carried out.

'Referring for a Community Support Activity in Mental Health' (RCSAiMH) Project

The Referring for a Community Support Activity in Mental Health (RCSAiMH) Project was established to improve referral processes for psychosocial support between Queensland Health (QH) and respective Community Managed Organisation partner organisations. A key component of the project was the adaption and inclusion of delegation training resources and the Allied Health Assistant framework for MHAODB into a toolkit for co-located services to formalise referral processes. The toolkit consisted of a practice guideline, implementation resources and education program to inform and embed referral practices and documentation.

The primary purpose of the toolkit was to:

- Define responsibility and accountability of organisations / staff involved in the referral of mental health consumers for community support activities
- Provide a process for collaboration, communication and negotiation of function for Queensland Health and Community Managed Organisations partner organisations around the referral and documentation of community support activities.

The toolkit was implemented on a trial basis at selected locations across Queensland, including: Nundah House (Alternatives to hospital facility); Gailes Community Care Unit; Cairns Community Care Unit; and Toowoomba Community Care Unit. However, due to unforeseen factors, Gailes CCU withdrew during the pilot.

Evaluation

The evaluation employed a mixed methods pre / post design using both qualitative and quantitative approaches. Data collection was via focus groups and included Allied Health

Professionals and staff of Community Managed Organisations at the study sites. The evaluation focused on staff perceptions and experience of implementing the RCSAiMH toolkit.

Discussion

Findings from this study provide strong support for the toolkit developed to facilitate implementation of the RCSAiMH initiative. Prior to the introduction of the initiative, staff of both organisations identified a number of shortcomings in the way consumers were referred to Community Managed Organisations and indeed, referred back to mental health. The process was perceived to be ambiguous and unstructured. The referral from one organisation to another was based mainly on verbal agreement between the partner organisations. This frequently resulted in a lack of clarity around the interventions to be provided and who and or which organisation was accountable.

The introduction and implementation of the RCSAiMH toolkit was perceived to provide a more structured approach to the referral process. While some services were already using some structured process / documentation, they valued the toolkit as they felt it reinforced what they were already doing (or trying to do). It was noted that most of these services used the toolkit resources to modify what they had in place to fit within the guidelines outlined in the toolkit. In some services, this required the development of new documentation or revision of existing key documentation to facilitate the new referral processes. In effect, each site developed its own referral process based on the guideline, toolkit resources and existing local processes on the ground. The toolkit provided enhanced resources to guide the development of this documentation and the processes underpinning the referral of consumers between organisations. The importance of integrating the toolkit with other documents and work instructions was noted by participants.

Each of the pilot sites felt that they had made good progress in implementing changes around referrals during the trial timeframe. However, each site did acknowledge that there was further work to be done to streamline and embed referral practices. For example, the importance of having the consumer included in the process of referral was highlighted by many of participants. It was noted that the consumer would need to be involved from the outset to ensure their participation. Others noted that future work could focus on having more culturally relevant tools in the toolkit especially in areas where there were greater numbers of a specific cultural group.

Although the initiative did add to the paperwork required at some services, it provided greater clarity around the roles and responsibilities of each organisation. Most respondents felt that the new process had provided an avenue for discussion and improved understanding around the purpose of assessments, care planning, and evaluation. For example, there was also a perception that the toolkit and related materials had improved Community Managed Organisations staff understanding of the assessments and interventions employed by Allied Health. On the other hand, Allied Health acquired a greater understanding of the role of psychosocial support workers and felt that the initiative had enhanced communication, accountability and working relations.

Although the findings reported here provide strong support for the initiative, further work is required to explore how it impacts on consumer outcomes. We did consider an audit of referral and clinical outcomes documentation but the COVID pandemic, and time and budget

constraints prevented this. The participants evaluated in the study from health were limited to allied health professionals and it is unclear how nursing and medical staff felt about the initiative. Finally, the study was limited to sites where health and Community Managed Organisation staff were co-located (as in a CCU). This provided greater opportunity for both groups of staff to plan and discuss interventions for each consumer (in addition to use of the toolkit). It is unclear how the initiative would operate in a service model where health and Community Managed Organisation staff were not co-located. Further evaluation work is required to assess this.

1 Introduction

1.1 Background

Over the past 10 years in Australia, there has been an increasing focus on the role of Community Managed Organisations in the provision of support to those with psychiatric disability (Hungerford et al. 2016). Government funding for Community Managed Organisations has increased significantly and the role of Community Managed Organisations in the provision of support services has become more clearly defined and accepted in the mental health field. The move has resulted in models care where mental health clinical staff work in collaboration with Community Managed Organisations to provide person-centred, community-based treatment and support for individuals with psychiatric disability (Shepherd & Meehan, 2012). This changing landscape has enabled Allied Health Professionals working in Mental Health Alcohol and other Drug Services (MHAODS) to re-examine their role and to have a greater focus on providing community treatment activities while Community Managed Organisations take on a greater role in providing support activities. This model of care, however, has not been fully maximised due to a lack of clarity around processes, governance, roles and responsibilities and mutual understanding of the scope of practice by the providers involved (Queensland Health 2017).

MHAOD services are increasingly entering into service level agreements with Community Managed Organisations who employ psychosocial support workers to deliver services at the consumer level. Psychosocial support workers come from a range of backgrounds and have developed skills and experience to optimise the support they provide to consumers. While the introduction of psychosocial support workers (through Community Managed Organisations) has promoted opportunities to develop new workforce solutions, new tools to define, articulate and support co-design of services will be required. An important factor will be the redistribution of activities and processes to support appropriate referral of work to these roles. This environment will also create opportunities to optimise the current scope of practice for the Allied Health Professionals in the MHAOD workforce (Queensland Health, 2017).

1.2 RCSAiMH Project Overview

As outlined, an integral component of the partnership between Queensland Health and the Community Managed Organisation sector is ensuring that appropriate consumers are referred to Community Managed Organisation for support. A recent initiative, the Referring

for a Community Support Activity in Mental Health (RCSAiMH) Project was established to improve referral processes for psychosocial support between Queensland Health and respective Community Managed Organisation partner organisations. A key component of the project was the adaption and inclusion of delegation training resources and the Allied Health Assistant framework for MHAODB into a toolkit for co-located services to formalise referral processes. The toolkit consisted of a practice guideline, implementation resources and education program to inform and embed referral practices and documentation.

The primary purpose of the toolkit was to:

- Define responsibility and accountability of organisations / staff involved in the referral of mental health consumers for community support activities
- Provide a process for collaboration, communication and negotiation of function for Queensland Health and Community Managed Organisation partner organisations around the referral and documentation of community support activities.

Development of the toolkit was informed by the following stages:

- An initial review of evidence from the literature, including nationally relevant position papers, guidelines and reports and peer reviewed articles relevant to collaborative practice and provision of community based psychosocial support
- Existing Queensland Health and Community Managed Organisation guidelines, resources and tools that inform current practices around the provision of community based psychosocial support and service agreements
- Key criteria identified and aggregated to provide the basis for the development of toolkit components guided by the RCSAiMH Project Steering and Reference Groups

The final / endorsed version of the RCSAiMH toolkit included the following components:

1. Guideline (recommended) and Implementation Resources (optional)
2. Companion Orientation Manual of Community Treatment and Support Tools (optional)
3. Self-guided learning package

Implementation

The toolkit was implemented on a trial basis at 3 locations across Queensland. It was initially trialled at:

- Nundah House (Alternatives to hospital facility), Metro North HHS
- Gailes Community Care Unit (CCU), West Moreton Health (WMH)

However, due to unforeseen factors, Gailes CCU withdrew during the pilot. As a result, two new sites were recruited into the study:

- Cairns Community Care Unit (CCU), Cairns HHS
- Toowoomba Community Care Unit (CCU), Darling Downs Health

1.3 Evaluation of the Initiative

As outlined, the toolkit was implemented on a trial basis at 3 sites in Queensland to enable evaluation of its perceived effectiveness. As the initiative represented a revised approach to the referral process, an independent evaluation was commissioned and supported by the Allied Health Professions' Office of Queensland (AHPOQ). The overall aim of the evaluation was to assess Queensland Health and Community Managed Organisation staff reactions to the implementation of the toolkit. The objectives included:

- Identify current issues impacting Allied Health Professional and Psychosocial Support Worker staff on referral practices for community support activities
- Examine the process supporting the implementation of the toolkit as perceived by Allied Health Professional and Psychosocial Support Worker staff referrals
- Examine the impact of the toolkit on Allied Health Professional and Psychosocial Support Worker staff perceptions on referral practices for community support activities

2 Evaluation Framework

2.1 Study Design and Duration

The study employed a mixed methods pre / post design employing both qualitative and quantitative approaches. The duration of the evaluation was set to align with key project milestones over the nine-month trial period (December 2018 to September 2019). However, due to several factors the project and consequently the evaluation timelines were extended for an additional 19 months (April 2021).

2.2 Scope

The evaluation focused on Allied Health Professional and Community Managed Organisation staff perceptions and experience of implementing the RCSAiMH toolkit. Outcomes for consumers receiving care during the pilot was not within evaluation scope. Furthermore, referrals to external community-based providers were also beyond evaluation scope, as sites selected for the project had existing co-located Queensland Health and Community Managed Organisation service agreements in place (e.g., CCU).

2.3 Study Participants

2.3.1 Allied Health Professionals (AHPs)

Allied Health Professionals employed at pilot sites were invited to participate in the study. This cohort included social workers, occupational therapists, psychologists, dieticians, and exercise physiologists. Allied Health Professional staff support consumer recovery through the assessment, planning and provision of clinical psychological and psycho-social care services.

2.3.2 Psychosocial Support Workers (PSWs)

Psychosocial Support Workers employed by Community Managed Organisations across all pilot sites were invited to take part in the study. The Community Managed Organisations providing services at the respective pilot sites include Mind Australia and Neami National. The role of Psychosocial Support Worker staff was to support consumers in achieving their recovery goals and assisting with non-clinical activities and tasks.

2.3.3 Team Leaders / Service Managers

Both Queensland Health and Community Managed Organisation Team Leaders / Service Managers from all four sites were invited to take part in the study. The role of this cohort was to support and guide their staff in the delivery of care services to consumers and represent their respective organisations within the partnership service agreement.

2.4 Data Collection and Analysis

2.4.1 Measures

In planning data collection, the evaluation tried to reach a compromise between the amount of data collected and the burden placed on staff during data collection. Data sources and collection methods are outlined in Table 1 and described in further detail below.

Table 1. Study Domains and Data Measures

Domain	Data Source	Measure	When
AHP and PSW staff perceptions on current referral practices for community support activities	AHP and PSW staff	Focus Group	Minimum 1-month pre-implementation
Implementation of the RCSAiMH Toolkit to support AHP and PSW staff referrals	AHP and PSW staff	Survey Focus Group	Following education session
Impact of the 'toolkit' on AHP and PSW staff perceptions on referral practices for community support activities	AHP and PSW staff	Focus Group	Minimum 6 months post-implementation

2.4.2 Data Collection

Pre-Implementation

Prior to implementation of the toolkit, eight focus groups were conducted: two at each of the four project sites with Allied Health Professional and Psychosocial Support Worker staff cohorts respectively. Questions focused on current staff perceptions and experience of:

- Current referral processes between Allied Health Professional and Psychosocial Support Worker staff
- Impact of current referral processes on delivery of collaborative care to consumers

- Impact of current referral processes on work scope / capacity
- Influencing factors on current referral processes

The pre focus group facilitation guide is provided in Appendix A.

Immediately prior to Implementation

Immediately prior to implementation, a two- hour online orientation workshop was delivered to all sites to introduce the 'toolkit' intervention and provide an overview of the learning package resources to support implementation. At the end of the workshop, a brief 4 item survey was administered to all participants to ascertain their views on the learning package and toolkit. A copy of the evaluation survey is provided in Appendix B.

Post-Implementation

Qualitative data on Allied Health Professional and Psychosocial Support Worker staff perceptions and experience of implementing the 'toolkit' on site and the impact on referral processes was also obtained via focus groups, held a minimum of six months after the orientation workshop. Questions included:

- Implementation plans and activities – generic and site specific
- Impact on referral processes between Allied Health Professional and Psychosocial Support Worker staff utilising the toolkit
- Impact on the delivery of collaborative care to consumers
- Impact on respective group work scope / capacity
- Influencing factors on referral processes

The post focus group facilitation guide is provided in Appendix C.

2.4.3 Data Analysis

Focus groups were conducted either in person or via videoconference and ranged in duration from 30 to 60 minutes. All focus groups were recorded with the permission of participants and transcribed verbatim from the recorded versions. Transcriptions were checked for errors against the recorded version to ensure accurate and authentic reproduction. Once checked, recordings were deleted. The analysis of focus group transcripts followed the process for extracting themes using a content analysis approach. The transcripts were reviewed several times to acquire a sense of flow and to generate a list of key ideas that reflected the sentiments of participants through their comments. Units of information that related to the same content were brought together and preliminary categories developed. After the categories were developed, they were reviewed for relevance, clarity, and completeness.

Data derived from the survey was combined to provide a general impression. Completed questionnaires were collated and coded to enable summary descriptive data to be produced.

2.5 Governance and Ethics

The RCSAiMH Steering Group provided oversight of the evaluation study. Representatives on the Steering Group were drawn from:

- Allied Health Professions' Office of Queensland (AHPOQ)
- Hospital and Health Service implementation sites
- Mental Health, Alcohol and Other Drugs Branch, Queensland Health
- Neami and Mind Australia
- Lived Experience Workforce

The evaluation was reviewed by the Metro North Health Human Research Ethics Committee and deemed to constitute a quality improvement activity; thus exempt from ethical review (LNR/2018/QRBW/48408). The project was undertaken in accordance with the NH&MRC guidelines on "*Ethical Considerations in Quality Assurance and Evaluation Activities*". Focus group participants were provided with written information about the evaluation (overview, process for managing data, and the questions to be posed) prior to the focus group. Verbal consent was obtained and recorded on tape prior to commencing each focus group.

3 Results

3.1 Current Referral Process (Pre-Implementation)

A total of 32 staff participated in 8 focus groups across the four pilot sites prior to the implementation of the RCSAiMH Toolkit. Discipline breakdown of participants were: 10 Allied Health Professional staff, 16 Psychosocial Support Worker staff and 6 Team leaders / managers. A range of themes emerged from the focus groups, that reflected the existing referral processes, prior to the implementation, and these are discussed in detail below.

3.1.1 No Formal Process for Referrals

All sites had formal agreements in place that provided broad direction in regard to key service provision requirements and co-located partners had developed some processes and policies to support the model of care. Referrals for psychosocial support occurring between the partners were mostly verbal and / or facilitated via existing shared staff meetings:

> *Very informally.... We really do not have a referral process, really only a conversation about who is going to do what. Things can be raised in handover or the clinical review meeting... it could just be an informal conversation because two people are sitting next to each other.*

Whilst partner organisations had their respective key documents and information to assess and monitor the provision of care to consumers, the lack of a shared, centralised information system for documentation hampered communication around referrals:

> *There is no space for information or documentation to be uploaded or shared jointly which I guess is quite a large barrier within our collaborative model...not having access to CIMHA ... or a joint system is a huge barrier in terms of sharing information and in giving out clients the best collaborative care.*

In response, sites had come up with a range of alternate processes to overcome this gap in information sharing and communication around referral requests. These included: individual or group emailing of key documents / consumer assessments; hardcopy printouts or handwritten notes:

> *It is done in a hard copy paper version at present simply because .... we don't have somewhere, like a server that we can both access and save documents. So, at this stage, it is a bit archaic in that it is a word document that the information for each person is cut and pasted into and gets emailed through.*

Staff at another service described how they print off hardcopies of assessments and care plans for sharing:

> *We have a very basic paper file which is called a paper light file which keeps original referrals and things like that. We don't have a shared file but we do have access to that file. We print off things like risk assessments, care plans … the sharing of information you often have to send in an email… you can print and hand over a piece of paper…but you then have to think about confidentiality…*

3.1.2 Referral Expectations Unclear and Referral Feedback Limited

Staff at all sites felt that communication around referrals could be improved for both partner organisations. Expectations of the consumer / referrer and clarification of recommended tasks / activities was one area of focus. The lack of documentation frequently resulted in ambiguity around what was required.

> *Not really the option of clarifying the information that is coming across as in you get the referral … a verbal request and you take your interpretation of it, but it may not mirror up with what they wanted … recommendations can get lost from a conversation if they aren't written down somewhere or followed through.*

This perceived lack of documentation also impacted on the feedback from the Community Managed Organisation on how referrals were being undertaken or progressed.

> *I think the follow up needs a lot of work because there doesn't seem to be a loop back…. of getting feedback from that referral to whether it has actually been actioned or not … if a clear process was in place, it would make us a lot more accountable for the actions taken.*

3.1.3 Informal Processes Impact Timely Provision of Care

The lack of structured documentation around care interventions seemed to impact on the provision of timely care to consumers. While good collaborative care was being delivered, respondents felt that it could be achieved more efficiently and effectively if appropriate documentation was in place to support structure:

> *I think we do better than a lot of places to be honest… the recovery model is pretty much in the front of our minds … I think we do that quite well.*

Being responsive … I guess that is a bit hit and miss. If somebody needs you, you will be there but in terms of structure and timing … is maybe a little lacking. Ultimately most consumers get to the end having achieved most of what they needed to achieve … it is probably just a bit messy on the way.

3.1.4 Influencing Factors on Referral Outcomes

Collaborative Relationships

Participants identified a number of factors that influenced referral outcomes. All sites indicated that a co-located service model promoted the collaborative working partnership between the Queensland Health and Community Managed Organisation teams:

There are good relationships with the people here which I think is critical. If we had poor relationships, I think that it would be a completely different scenario because we are functioning on relationships a lot here rather than actual processes. We are getting by on the fact that we have a good standing with each other rather than structures supporting or facilitating a lot of this work.

Understanding of Roles and Responsibilities

The understanding between partners of their respective roles, responsibilities and scope of work also underpinned referral practices:

With scope of practice…we sat down together as teams and clearly identified what our roles were. It was a really good starting point because I think that it was unclear before…. where everyone's roles started and finished. There is a greater understanding of what does fit within different vocation's scope of practice and that then has also allowed people to grow their individual practice scope as well.

Staffing Continuity

Changes in staffing arrangements, stability and rostering also had a large impact on referral processes:

Rosters have a big impact. If you take into account, the Allied Health staff are here Monday to Friday but the nursing and Community Managed Organisation staff are on shifts…it does create quite a bit of difficulty around negotiating timeframes and being able to catch up.

And

Changes to staffing is challenging … it brings a lack of consistency in leadership, approaches, and implementation.

Type of Service Model

Finally, the purpose of the facility and the consumers being admitted also influenced referrals:

I think we are a bit different to some places such as CCUs, because sometimes our decision making about things is dictated by time. People are only here for two weeks… not a long period of time. Our clients also tend to be more highly functioning to be able to do things themselves. The meaning of the term support and how it is provided will be quite different.

3.2 Implementation of the RSCAiMH Toolkit

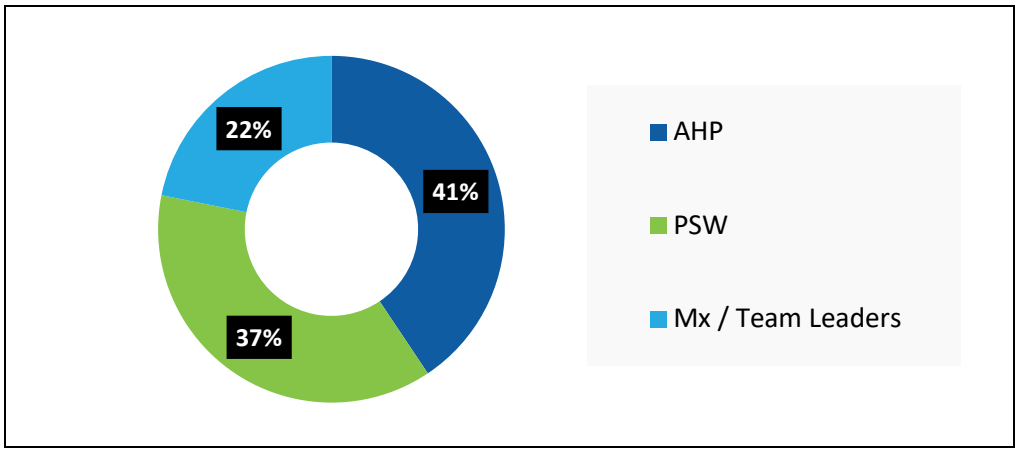
3.2.1 Workshop Evaluation

A two-hour online orientation workshop was conducted with all sites prior to the implementation of the toolkit. This included an overview of the RCSAiMH project, familiarisation with documents and resources within the toolkit to support implementation and the opportunity to ask questions. A total of 33 staff completed the evaluation survey: 17 from Queensland Health and 16 from the respective Community Managed Organisations.

Respondents

A breakdown of the discipline group of respondents is provided in Figure 1.

Figure 1. Respondent Disciplines



Content

Respondents were asked to rate the content of the learning package in terms of their learning and knowledge around referral for community support activity and individual interest. Respondent ratings ranged from 'not at all' to 'extremely' for each statement. Overall, those who submitted a completed survey were generally satisfied with the session (Table 2).

Table 2. Respondent Ratings

Questions	Rating % (Frequency)					Total
	Not At All	Slightly	Moderately	Quite A Bit	Extremely	
Content assisted learning and knowledge about referring for a community support activity	0% (0)	3.0% (1)	42.4% (14)	39.4% (13)	15.2% (5)	**100% (33)**
Content was interesting	0% (0)	3.0% (1)	42.4% (14)	39.4% (13)	15.2% (5)	**100% (33)**

Feedback

Respondents were asked to provide written comments on the aspects of the learning package that worked well. Analysis of these comments pointed to the following themes:

- Greater clarity around roles and responsibilities of Queensland Health and Community Managed Organisation staff
- Emphasis on collaborative nature and work within partnership / referral processes
- Provision of practical examples / templates
- Opportunity to ask questions

Feedback was also provided on aspects of the learning package that could be improved. Areas to target included: provide physical copies of resources, more clarity / focus on providing a collaborative feedback loop between partners, discipline specific examples and inclusion of staff experiences / perspectives on how to implement on daily basis.

3.2.2 Implementation Strategies

A total of 32 staff participated in 6 focus groups across the three remaining pilot sites to reflect on the implementation of the RCSAiMH Toolkit. Discipline breakdown of participants were: 10 Allied Health Professional staff, 16 Psychosocial Support Worker staff and 6 Team Leaders / Managers.

Orientation workshops

The online orientation workshop provided a good overview of the broader project and available resources. However, each site sought to develop strategies and resources to support implementation at the local level. In line with this, each site developed its own referral process based on the guideline, toolkit resources and existing processes on the ground:

> *We started firstly .... we started out by educating staff about the process and then we developed the longitudinal summary that we use for our MDT. We had a referred to community support activity type criteria so that we could document the referral for consideration, what the referral was and then go back and add the interventions. We ran a couple of presentations to the CMO and nursing staff that allied health staff led to I guess clarify the process.... just really breaking down the types of activities we would refer on and I guess the levels of support each consumer may need.*

At another service, staff noted that the toolkit added 'theory' and support for what they were already doing:

> *I suppose a big part of the toolkit and what it achieved was adding detail and theory behind what we were already doing here... considering the majority of the document we used haven't changed. It is more like us putting some input into what forms we use and how we communicate.*

Change Management processes

In line with the flexible nature of how the resources and orientation manual could be implemented, sites utilised these materials to varying degrees to provide a best fit for their local context:

> *I think the toolkit companion was really great...there is a huge amount of information in it and some really great resources. I think that they have been really helpful otherwise I think we would have been lost if we didn't have the toolkit, standardised measures, and actual activities to use.*

The importance of integrating the toolkit with other documents and work instructions was noted.

> *One of the most difficult things in implementing in the CCU space was that we somehow had to make sure that it would be well combined with our other suite of documents, processes and service model.*

3.3 Referral Process Post-Implementation

A range of themes emerged from the post-implementation focus groups, that reflected the service changes that had occurred following the implementation, and these are discussed in detail below.

3.3.1 More Formalised Process for Referrals

Each of the sites reported a more formal process for referrals following the introduction of the toolkit. It was clear that they had implemented or were working towards implementing the new guidelines within the existing co-location service model arrangements. This required the development of new documentation or revision of existing key documentation to facilitate the new referral processes. Other modifications included changes to case review and Multi-Disciplinary Team meetings to provide time for discussion of referrals:

> *That is what this document was for when we decided to create it…we wanted it to be a two-way referral sort of system. So, the tasks that come from case review are just divided out between the staff and followed up. It is kind of for everyone to be able to refer to…to use and see what tasks need to be completed.*

The toolkit was also seen as adding clarity to the process of referring a consumer for support to a Community Managed Organisation. It seemed to streamline the process and add accountability in the transfer of care between one organisation and another:

> *I think we enjoy a much clearer framework…enjoy the fact that there is accountability and we can use documentation. Like … for example, in our case review / transfers of care.*

A shared or centralised system to act as a conduit for communicating information between co-location partners was perceived to be beneficial. Community Managed Organisation staff ability to access CIMHA during the pilot was felt to be a positive development in terms of sharing information, tracking progress, and storing documentation:

> *The staff are using the documentation on the longitudinal summary to go in and update progress regularly. Community Managed Organisation access to CIMHA has certainly assisted with the communication process and being all on the same page.*

Shared access to CIMHA was also considered to be important in promoting a 'partnership' between the organisations in that both organisations had equal access to consumer information:

Shared access to CIMHA has helped… a lot of paper and time saving, I can now give a really brief 2–3 minute handover and say there is more detail available on my assessment notes in CIMHA that you can look through. They can always go look in CIMHA and get a better understanding. If you are doing documentation and have the same access to information … I think psychologically you feel more like one…you're on an even playing field. It is not like one partner has all the information and the other only get 20% of it. It did change things positively.

Whilst CIMHA was useful as a central repository, Community Managed Organisation staff were limited to entering updates on psychosocial activities and tasks as a general progress notes that was not readily identifiable in terms of a specific referral or staff member. Respondents did report that trying to locate information about a specific task or activity within multiple consumer files was time consuming and laborious:

The Community Managed Organisation staff can only use an NGO progress note which is really generic. If they were able to POS with their own set of intervention codes, it would be much clearer…otherwise you are scanning through a multitude of general progress notes to look for that activity. So, the process still relies on communication through emails, meetings, or discussion.

As a result, some sites adopted other strategies to ensure centralised and timely access to relevant information, particularly for staff who had been on leave or could not regularly attend Multi-Disciplinary Team or case review:

We have a hard copy of the task planner that sits between the Community Managed Organisation desks and is easy for us to refer to…. it has formalised tasks for Queensland Health and the Community Managed Organisation I think for me… as I don't attend case review…it gives me an indication of what we are expected to do the following week. Otherwise I would have to go through 10 consumers' CIMHA notes looking for anything relevant. I can now also add in stuff as well for either Queensland Health or the Community Managed Organisation to follow up.

3.3.2 Increased Clarity Referral Expectations

All participants felt that the new processes allowed for better alignment of Queensland Health and Community Managed Organisation referrals in achieving consumer recovery goals:

I think it currently works well for the consumers because you are working together on the same goal … the consumer will know that we are working as a team. So, I think that in this situation working as one team regardless of who employs you works really well for the consumers.

And

I think it has helped us work together as a team more whereas I felt from the start that there were two separate teams tracking in the same direction. But I feel that the teams are working together better...

However, some participants did report differing levels of understanding and expectation by consumers, Allied Health Professionals and Community Managed Organisation staff as to the differences between a goal and activities / tasks that could contribute to achieving it:

From the beginning I thought it was a collaborative kind of thing with the consumer...a lot of the time I felt the referrals had been done without a whole lot of consultation with the consumer and the end goal was not always clear for the person. I think a lot of people found that there wasn't enough breakdown in what the goal actually was... not enough direction as to what individual tasks could make up working towards the goal. To have that much more explicit and clear would be very helpful and useful.

The importance of having the consumer included in the process of referral was highlighted by many of participants. It was noted that the consumer would need to be involved from the outset to ensure their participation:

I think the consumer needs to be on board with it ... the referral from the very beginning. If they don't see it as an issue to get them on board and interested and learning about that was quite challenging. But that said too, maybe putting the consumer's signature on that referral form might bring a bit more accountability for that person too...have all three people agreeing to implement that.

Most respondents felt that the new process had provided a number of avenues to allow for better clarification and consistency in how tasks could be implemented. Discussion and improved understanding around the purpose of assessments, access to additional information via CIMHA and the resources / tools within the toolkit were some of the methods mentioned:

I think the tools... our guys are so busy and to have that as a guideline just makes it that bit more easy to implement and carry out every day. It also gives consistency...there are different people everyday doing the task with someone, it is being done the same way and that can only benefit the person. I think what it would decrease is the questionability and sometimes for want of a better word...frustration about not being able to find the right method to teach somebody or do something or give active support to someone.

There was also a perception that the toolkit and related materials had improved Community Managed Organisation staff understanding of the assessments used by Allied Health:

> *It has increased the knowledge and understanding of the Community Managed Organisation staff of all the different Allied Health assessments. There has been a desire to learn what a certain assessment is and what it may mean for how they communicate. Even being able to grasp a history of a person, discuss it in Multi-Disciplinary Team and understand the reasons for what is recommended in terms of referral.*

3.3.3 Collaborative Care Pathway and Flow Improvements

Participants felt that the changes around the referral processes provided greater continuity in care for consumers as well as the capacity to be more proactive and responsive.

> *We have an upgraded case review note that leaves some blank space so that we can add on tasks.... we can react in a more timely basis. Say if someone comes in mid-week and it is four days until case review, we can already note some tasks for both us and CMO to get started on. In that respect, I would say that consumers are getting a better quality of care...interaction with us and interaction from us as well.*

It was also noted that the initiative has improved accountability over the duration of the trial:

> *Personally, I think it has provided us a lot more structure in how to provide certain assistance to people. There is a level of accountability that is there now that wasn't previously...it has been a positive experience and led to better outcomes for consumers here.*

The feedback loop on the progression of referrals had also improved, ensuring consistency in care planning and accountability for both partner organisations:

> *When you have a consumer, who is staying on average for two weeks...we need to know exactly what to focus on because two weeks is not a lot of time. So, having a task allocated so people know exactly what to focus on... it is there in writing. You don't want to get to the end of the two weeks and realise no one has done that...it just keeps everyone accountable.*

And

> *Having it written down...it adds to the follow up and that 360 feedback and accountability loop to be able to review it and determine what has been achieved to date and what still needs to be done.*

3.3.4 Ongoing Service Improvement Identification

Each site felt that they had made good progress in implementing changes around referrals during the trial timeframe. However, each site did acknowledge that there was further work to be done to streamline and embed referral practices:

> *It went pretty well from the start, but I think it is the human part of it that let it down. The documentation is ok and the process I think is ok … it is just the follow up and staffing inconsistencies were a little bit problematic.*

Some staff did raise the issue of having more culturally relevant tools in the toolkit especially in areas where there are high populations of a particular cultural group:

> *There is potentially scope to use or include more indigenous or culturally competent tools for some activities… particularly in areas with high population or resident groups*

4 Discussion

The emphasis on consumer-centred recovery in the mental health field in Australia and overseas has led to significant changes in the way in which care is provided to those with psychiatric disability (Rosenberg, 2011; Shepherd & Meehan, 2012). In Queensland, MHAOD services are increasingly entering into service level agreements with Community Managed Organisations to provide a range of psychosocial support services to complement those provided by clinical mental health services. A key factor in the success of this reform agenda is the redistribution of work between mental health staff (i.e., Allied Health Professionals) and Psychosocial Support Workers (Shepherd, Meehan & Humphries, 2014). One initiative established in 2019 to facilitate this process was the 'Referring for a Community Support Activity in Mental Health' (RCSAiMH) Project. This initiative, developed through the Allied Health Professions Office of Queensland, was designed to improve the way in which referral processes for psychosocial support between Queensland Health (QH) and respective Community Managed Organisations partner organisations are carried out.

Findings from this study provide strong support for the 'toolkit' developed to facilitate implementation of the RCSAiMH initiative. Prior to the introduction of the initiative, staff of both organisations identified a number of shortcomings in the way in which consumers were referred to Community Managed Organisations and indeed, referred back to mental health. The process was perceived to be ambiguous and unstructured. The referral from one organisation to another was based mainly on verbal agreement between the partner organisations. This frequently resulted in a lack of clarity around the interventions to be provided and who and or which organisation was accountable for the timely provision of care.

The introduction and implementation of the initiative / toolkit was perceived to provide a more structured approach to the referral process. While some services were already using

some structured process / documentation, they valued the toolkit as they felt it reinforced what they were already doing (or trying to do). It was noted that most of these services used the toolkit resources to modify what they had in place so as to fit within the guidelines outlined in the toolkit. In some services, this required the development of new documentation or revision of existing key documentation to facilitate the new referral processes. In effect, each site refined its referral process based on the guideline, toolkit resources and existing local processes on the ground. The toolkit provided enhanced resources to guide the development of this documentation and the processes underpinning the referral of consumers between organisations. The importance of integrating the toolkit with other documents and work instructions was noted by participants. The improved structure resulted in perceptions of a more collaborative care pathway allowing for greater clarity around referral expectations for staff and consumers and more consistent mechanisms for feedback on referral progression.

Although the initiative did add to the paperwork required at some services, it provided greater clarity around the roles and responsibilities of each organisation. Most respondents felt that the new process provided an avenue for discussion and improved understanding around the purpose of assessments, care planning, and evaluation. There was also a perception that the toolkit and related materials had improved Community Managed Organisations staff understanding of the assessments and interventions employed by Allied Health. On the other hand, Allied Health acquired a greater understanding of the role of Psychosocial Support Workers and felt that the initiative had enhanced communication, accountability and working relations.

Each of the pilot sites felt that they had made good progress in implementing changes around referrals during the trial timeframe to support consumer engagement and recovery goals. The importance of collaborative care planning, and having the consumer included in the process of the referral was highlighted by many of participants. It was noted that the consumer needs to be involved in care planning and goal setting from the outset to ensure engagement and participation.

Although the findings reported here provide strong support for the initiative, each site acknowledged that there was further work to be done to streamline and embed referral practices. Also, further work is required to explore how it impacts on consumer outcomes. We did consider an audit of referral and clinical outcomes documentation but the COVID pandemic, and time and budget constraints prevented this. The participants from health were limited to allied health professionals and it is unclear how nursing and medical staff felt about the initiative. Future work could focus on having more culturally relevant tools in the toolkit especially in areas where there were greater numbers of a specific cultural group.

Finally, the study was limited to sites where health and Community Managed Organisations staff were co-located (as in a CCU and Step Up / Step Down short stay facility). This provided greater opportunity for both groups of staff to plan and discuss interventions for each consumer (in addition to use of the toolkit). It is unclear how the initiative would operate in a service model where health and Community Managed Organisations staff were not co-located. Further evaluation work is required to assess this.

5 References

Hungerford et al. (2016.) Recovery, non-profit organisations and mental health services: “hit and miss’ or ‘dump and run’. International Journal of Social Psychiatry, 62, 350-360.

Parker S, Dark F, Vilic G, et al. (2016). Integrated staffing model for residential mental health rehabilitation. Mental Health and Social Inclusion 20: 92-100.

Queensland Health. (2017). State-wide Mental Health Allied Health Scope of Practice Project Report: Community Adult Mental Health Services. https://www.health.qld.gov.au/data/assets/pdf_file/0044/649997/mhapsp-project-final-report.pdf

Rosenberg, S. (2011). True north?: Twenty years of Australian mental health reform. International Journal of mental Health, 40, 8-24.

Shepherd, N & Meehan, T (2012). A multilevel framework for effective interagency collaboration. Australian Journal of Public Administration, 71 (4), 403-411.

Shepherd, N., Meehan T, & Humphries, S (2014). Supporting recovery: challenges for in-home support workers. Mental Health Review Journal 19(2), 73-88.

6 Appendices

Appendix A. Pre-Implementation Focus Group Schedule AHPs & PSWs

Background to be provided by interviewer to AH professionals

The purpose of this project is to improve the process used by Allied health staff to refer a person with mental health issues to a Community Managed Organisation. Referring for a Community Support Activity in Mental Health' is designed to provide a service model to enhance allied health workforce capacity and scope of practice through piloting Guidelines and resources to inform working when referring for community support activities between HHS staff and community managed organisations. We would like to ask you some questions about the current process.

1. How are referrals currently made between AHP MHAOD and CMO staff?
2. How are referrals currently accepted CMO staff?
3. What works well with the referral system?
4. What does not work so well with the referral system?
5. What impact does the current model of care (referral process) have on:
    a. Pathways to provide consumers with the right care at the right time
    b. Optimising support of consumers by community managed organisations
    c. Collaborative processes between AHP MHAOD and CMO staff
    d. (for AHPMHAOD only) capacity for AHPMHAOD to work to their profession full scope

Attachment 2: Interview Schedule PSWs

Background to be provided by interviewer to PSWs

The purpose of this project is to improve the process used by Allied Health Professionals to refer a person with mental health issues to a Community Managed Organisation such as Mind Australia or NEAMI. We would like to ask you some questions about the current process.

1. What is your understanding of the current process used by Allied Health professionals to provide referrals for a community support activity
2. How are referrals currently made between AHP MHAOD and CMO staff?
3. How are referrals currently accepted CMO staff?
4. What works well with the referral system?
5. What does not work so well with the referral system?
6. What impact does the current model of care (referral process) have on:
    a. Pathways to provide consumers with the right care at the right time
    b. Optimising support of consumers by community managed organisations
    c. Collaborative processes between AHP MHAOD and CMO staff

Appendix B. Evaluation Learning Package Workshop

Please identify your role by ticking the box below

☐ **Psychosocial support worker**

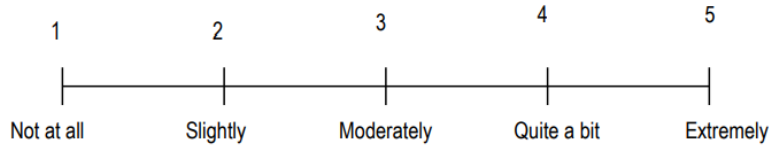
☐ **Clinical nurse/nurse manager**

☐ **Psychiatrist/medical officer**

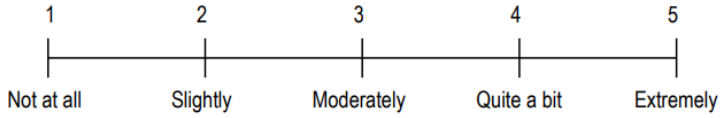
☐ **Allied health professional**

☐ **Manager/team leader**

1. Overall did you find the content of the **learning package** assisted your learning and knowledge about referring for a community support activity?



2. Overall did you find the content interesting?



3. Please comment on aspects of the **learning package** that worked well and facilitated your learning.

4. Please comment on aspects of the **learning package** that could be improved and did not facilitate your learning.

Appendix C. Post-Implementation Interview Schedule AHPs, PSWs & Managers

Background to be provided by interviewer

The purpose of this project is to improve the process used by staff to refer a person with mental health issues to a Community Managed Organisation. 'Referring for a Community Support Activity in Mental Health' is designed to provide a service model to improve consumer clinical pathways, collaboration between community managed organisations and Queensland Health, and enhance allied health workforce capacity and scope of practice through piloting Guidelines and resources to inform working when referring for community support activities between HHS staff and community managed organisations. We would like to ask you some questions about the current process.

The toolkit consists of a

1. **Referring for a community support activity in Mental Health Services Tool Kit: Guideline and implementation resources** that includes:
    - **The Guideline: Referring for a Community Support Activity in Mental Health**, defines responsibilities and accountabilities of Hospital and Health service mental health alcohol and other drug services staff associated with the referral and review of community support activities. The process emphasises collaborative working principles to provide communication and operational processes to facilitate the referral between organisations.
    - **The implementation resources** support the operationalisation of the Guideline. While the processes in the Guideline are recommended, the implementation resources are optional and could be applied according to the nature of the service agreement, the type of service and the specifics of the referral. The implementation resources include the list of consumer support activities, the terms for the partnership agreements, the consumer skills development model and the referral forms.
2. **Referring for a community support activity in Mental Health Services Tool Kit: Companion orientation manual of community treatment and support tools.** The intention of the collection of community support and community treatment tools is to orientate allied health and psychosocial support workers to the type of tools that they use when supporting consumer recovery. They are optional generic resources that can be adapted for use based on the consumer needs and assessment or used as a discussion point between allied health professionals and community managed organisation staff.
3. **Self-guided learning package** that orientates Hospital and Health Service mental health and alcohol and other drugs services and community managed organisation staff that plan to implement the model of care.

1. Please comment on
    i. aspects of the **Toolkit** that worked well and facilitated your ability to provide referrals (allied health)/ or receive referrals (psychosocial support workers) for a community support activity (triggers in dot points below if they need it, the toolkit…..)
        - … it described processes for effective activity referrals
        - ….it defined the governance processes that need to be in place before the implementation of community support activities
        - …it described the roles and responsibilities of the staff involved in providing and receiving referrals
        - …it enhanced understandings of the scope of practice by the providers.
        - …it provides principles around effective activity service requests
    ii. What were the most useful components of the toolkit e.g. Guideline, implementation resources (including service agreement and referral templates), companion orientation manual (non-clinical resources for allied health professionals and psychosocial support

workers), education package, specific implementation resources, e.g. referral form, lists of support activities.

2. Please comment on aspects of the **Toolkit** could be improved and did not facilitate ability to provide or receive referrals for a community support activity.

The next questions relate to the service model

3. Do you think the service model process of making referrals for a community support activity in this context

   a) improved the pathway that provides consumers with choice and the right care at the right time? If so how?

   b) improved the collaborative processes between HHS mental health and alcohol and other drugs services and community managed organisations? If so how?

   c) Increased the capacity for, Allied Health Professionals (AHP) to work to their profession scope of practice? If so how?

   d) optimised the support of consumers by community managed organisations? If so how?

4. How could the service model be improved?