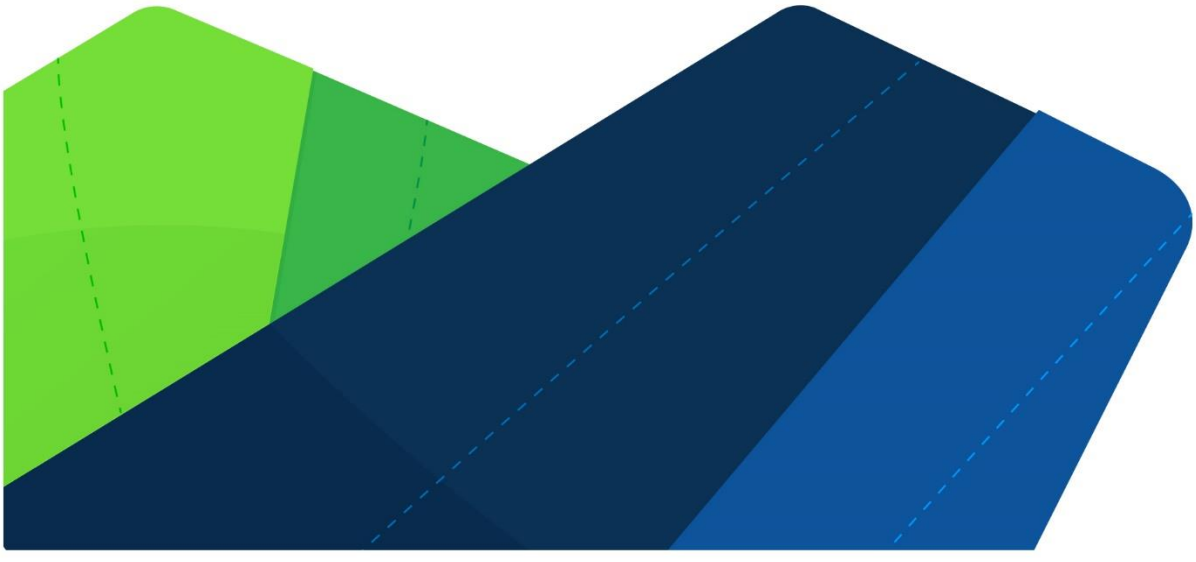
Referring for a Community Support Activity in Mental Health Services

Toolkit: Guideline and implementation resources

A partnership with Neami National and Mind Australia

Neami National
Improving Mental Health and Wellbeing

mind
Supporting mental health recovery



Queensland Government

Referring for a Community Support Activity in Mental Health Services: Toolkit – Guidelines and implementation resources

Published by the State of Queensland (Queensland Health), July 2021.

For more information contact:
Allied Health Professions' Office of Queensland, Department of Health, PO Box 2368, Fortitude Valley BC, QLD 4006, email allied_health_advisory@health.qld.gov.au, phone (07) 3328 9298.

An electronic version of this document is available at https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/allied-health-mental-health-initiatives

Contents

Acknowledgements

The Allied Health Professions' Office of Queensland would like to acknowledge the contributions of Mind Australia, NEAMI National, Gailes Community Care Unit, Nundah House Alternatives to Admission, Darling Downs Community Care Unit, Cairns Community Care Unit and the steering and reference group members in the development of this resource/toolkit.

Steering Group members:

Julie Hulcombe, Catherine Stephens, Fiona Hall, Valda Dorries, Kylie Garrick, Denise Cumming, Sarah Hamilton, Bernadette Klopp, Ailie Perish, Karen Thomas, Gabrielle Vilic, Tarryn Mullavey, Nathan Dart, Debra Barker, Michelle Giles, Zonia Weideman and Marea Webb.

Reference Group members:

Bernadette Rogerson, Sandra Henderson, Fiona Jarrett, Samantha Bicker, Carin van Grunsven, Adam Lo, Rebekah Lewis, Bridget Duffin, Lauren Merchant, Sarah Johnson, Fiona McMaster, Kerrie Humphries, Nithya Kunasakaran, Paula Arro, Margaret Hoyland, Jacklyn Whybrow, Suellen McKerlie, Kathrin Peisker and Melissa Robertson, Brendan Murdoch, Janet Foster, Adam Weatherill, Alana Aspinall, Peter Kelsey, Sam Grimes, Mary Streatfield, Leonie McAuliffe, Suzanne Riach, Sheena Peck Emma Mauro, Merianne McGregor, Zeb Moody, Leanne Lilly, Fiona Ford, Sean Devine, Lisa Mercer, Doug Sterns, Ellen Firrell, Clare Findlay and Nancy Ong.

Introduction

The Referring for a Community Support Activity in Mental Health model of care enhances referrals for community support activities between allied health professionals employed in Hospital and Health services and psychosocial support workers employed through community managed organisations. The model of care is support by this 'toolkit' that has been co-designed to improve the referral of a person with a mental health problem to a community managed organisation, it consists of:

1. **Referring for a community support activity in Mental Health Services Toolkit: 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 partnership 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 agreement, the consumer skills development model, referral forms, and case studies and orientations from two of the implementation sites.
2. **Referring for a community support activity in Mental Health Services Toolkit: 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.

Although the Guideline includes referrals by allied health professionals to community managed organisations, it could be applied to all mental health and alcohol and other drugs services clinicians. Also, while they specifically pertain to requests to community managed organisations, the principles could apply to internal **Hospital and Health Service** mental health and alcohol and other drugs services for example the peer support workforce.

The services that implement the referring for a community support activity vary and may include sub-acute services, for example adult step up/step down units and in-reach hospital to home services; community services, for example case management, outreach services and transitional recovery programs; and long-term services, for example community care units and rehabilitation services. It may also have application when referring to the NDIS.

Background

With government funding increasing directed to community managed organisations to provide community support activities, there are opportunities for initiatives where allied health professionals in mental health alcohol and other drug services provide community treatment activities and community managed organisations provide community support activities. This model of care however, had not been 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).

Mental health alcohol and other drug services are increasingly entering into service level agreements with community managed organisations to provide community treatment and support activities to optimise the support for consumers. However, providers have identified complexities around how the roles of psychosocial support workers in community managed organisations are defined and utilised.

As psychosocial support workers from community managed organisations are engaged in providing services there are opportunities to develop new workforce solutions. Redistribution of activities and processes to support appropriate referral of work to these roles can be embedded in workforce design and the models of care. This environment also creates opportunities to optimise the current scope of practice for allied health professionals in the mental health alcohol and other drug workforce (Queensland Health, 2017). The Referring for a Community Support Activity in Mental Health project has been undertaken to adapt delegation training resources and the allied health assistant framework for Hospital and Health Service mental health and alcohol and other drugs services and community managed organisations that deliver community support services. While the allied health assistant framework refers to delegated tasks, this project had a different context with community managed organisations performing community support activities without instruction from the Hospital and Health Services, with the underlying driving principle of team work and collaboration. The project outcome was this finalised toolkit that supports Hospital and Health Service mental health and alcohol and other drug services clinicians.

The Referring for a community support activity model of care and toolkit informs the current and ongoing development of services and provides a pathway to provide consumers with the right care at the right time, optimises the support of consumers by community managed organisations and collaborative processes between Hospital and Health service mental health and alcohol and other drugs services and community managed organisations; and increases capacity for mental health and alcohol and other drugs services, allied health professionals to work to their profession scope of practice.

Guideline: Referring for a Community Support Activity in Mental Health

Purpose of the guideline

The Guideline has been prepared to facilitate referrals to community managed organisations and provides support for Hospital and Health Service (HHS) staff to refer between community managed organisations and HHS mental health and alcohol and other drugs (MHAOD) staff. It defines responsibilities and accountabilities of HHS MHAOD staff associated with the referral and review of community support activities. The Guideline emphasises collaborative working principles to provide communication and operational processes to facilitate the referral between organisations. This Guideline is intended to enhance allied health professional (AHP) scope of practice and support appropriate workload allocation and enhance consumer outcomes.

Scope

The Guideline applies to AHPs working in HHS MHAOD services. The Guideline specifically pertains to the request to community managed organisations but the principles could apply also to referral by AHP to internal HHS MHAOD services for example the peer support workforce.

Note: While these Guidelines apply to AHPs, it is understood that they could have application to all MHAOD service clinicians.

Definitions

Community support activities form part of a community support service provided by a community managed organisation or HHS MHAOD service. They support the recovery of consumers whose lives are affected by mental illness, and helps realise individual recovery goals. Community support activities may be delivered by a psychosocial support worker in a community managed organisation or a peer support worker in a HHS MHAOD service. These activities do not involve any direct clinical care or clinical decision making and have negligible risk associated with them, but may be relevant to clinical care planning by the AHP. Community support activities, detailed in Appendix 1, include:

- consumer and carer engagement and participation
- recovery support
- information collection and recording.

Community support services are defined as a range of services including group support, individual support, peer support, and psychosocial rehabilitation for those experiencing severe and persistent mental illness as well as support for families and carers. These community support services are delivered by community managed organisations *(*Connecting Care to Recovery 2016-2021, p.11 and informed by the National Mental Health Planning Framework).

Why would you refer for a community support activity?

- Assist consumers to achieve recovery goals through access to community support services that utilise a diversity of supports.
- To improve health outcomes for adults with mental illness through improved pathways to provide consumers with the right care at the right time.

Governance

Before the implementation of community support activities, the appropriate governance should be in place**:**

- Community support activities are included as part of a collaboratively developed local partnership agreement (LPA) or equivalent, between HHS MHAOD and the community managed organisation.
- Examples of the terms of an LPA as they relate to community support activities can be found in Appendix 2.
- The terms of the LPA will describe robust clinical governance across services including ensuring that the workforce has the capacity and capability to provide requested community support activities.
- The LPA should clearly define the extent and scope of the services provided, examples of the types of activities, and service evaluation outcomes associated with the community support activities.

Principles of effective activity service requests

The following overarching principles apply when implementing community support activity practice:

- Consumers are supported to develop and maintain social, recreational, occupational and vocational activities which are meaningful to them.
- The primary motivation for referring for community support activities is to serve the best interest of the consumer.
- The AHP determines the need for the community support activities in collaboration with the consumer, carers and community managed organisation as part of joint recovery planning and the multidisciplinary team care process.
- Working collaboratively and respectfully with the community managed organisation and partners is fundamental to the success of the Guideline.
- Collaboration with the community managed organisation and review of the consumer's progress toward their agreed recovery goals are integral to holistic collaborative care and should inform multidisciplinary care planning and review.

Prerequisites for effective service requests

- Services involved in the implementation of the Guideline will ensure that a process/protocol is in place to guide information sharing and communication.
- Prior to implementing community support activities all AHPs will have a clear understanding of what should be referred and the related shared responsibilities and accountabilities. The National Framework for recovery orientated mental health services, The National practice standards for the mental health workforce and the Psychosocial Rehabilitation Support Service Standards informs the understandings of the scope of practice of the psychosocial support workers.
- AHPs should orient Community Managed Organisation staff to the relevant Queensland Health clinical documents/forms during collaborative planning processes.

- HHS MHAOD and community managed organisation staff are aware of and uphold responsibilities and accountabilities in the provision of care for the consumer and encourage collaboration between the service sectors.
- Escalation processes and protocols should be clearly defined and accessible should there be barriers to fulfilling the community support activity. Risk management policies and procedures should be detailed under the service level agreement/partnership agreement, refer Appendix two, section 3.1.
- There is a reciprocal arrangement/two way referral process and the MHAOD AHP could be referred a community treatment/clinical service by the community managed organisation if specialist input is required for consumers who meet the eligibility for assessment and treatment within the mental health service.
- All HHS MHAOD employees must comply with:
  - legislative and policy requirements regarding confidentiality and privacy.
  - National Safety and Quality Health Service Standards (second edition)
  - National Standards for Mental Health Services (2010).
  - Queensland Health documentation requirements.
  - Other relevant Queensland Health guidelines policies and supporting documents.
- The services that implement referring for a community support activity vary and may include:
  - sub-acute services for example Adult Step Up/Step Down Units and in reach Hospital to Home services, see Appendix 4 implementation resources for subacute services
  - community services for example a case management, outreach services or transitional recovery programs
  - long-term services for example Community Care Units and rehabilitation services, see Appendix 5 implementation resources for long-term services
- The implementation resources within the toolkit could be applied according to the nature of the Local Partnership agreement and the type of model of care.

Process of effective activity service referrals

How to refer for a community support activity:

- The AHP referring:
  - ensures a current diagnosis, clinical management and treatment plan and case review timeframes are documented as a part of clinical care and the care plan.
  - determines whether it is appropriate to refer for a community support activity to community managed organisation staff who provide community support services.
  - obtains written or verbal consent from the consumer
- Collaboration with the community managed organisation and review of the consumer led progress toward their recovery goals are an integral part of holistic collaborative care and should inform multidisciplinary care planning and review.
- The referral occurs through one of the following processes:
  - during a stakeholder or service meeting with the community managed organisation where the team leader or operational manager accepts the referral, see Appendix 4 and 5
  - as a telephone referral.

- written referral from the AHP to the community managed organisation using an agreed procedure for referral between agencies e.g. HHS MHAOD or community support service referral procedure, see Appendix 4 and 5.

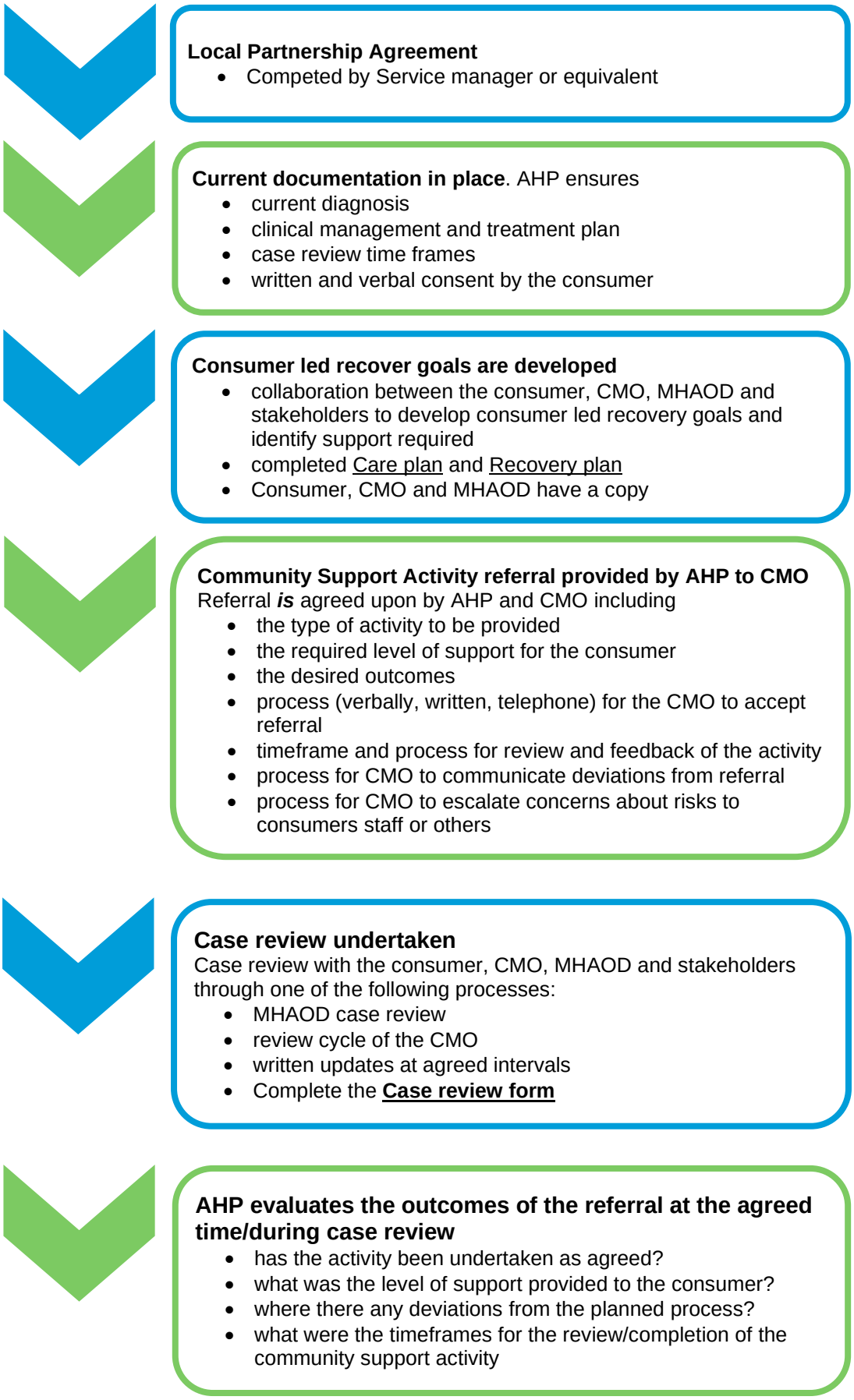
- Documentation of the referral by the HHS MHAOD staff member should be included in the clinical record detailing the purpose and outcome of the referral.
- At the time of organising the community support activities for the consumer the AHP provides clear instructions about the expectations and establishes the feedback process including a description of:
  - the type of activity (refer to Appendix one, community support activities) and the required level of support to be provided to the consumer e.g. activity performed with support, independently or with prompts. The Consumer skills development model is a decision making tool that provides a common understanding between AHP, psychosocial support worker and Consumer of what the psychosocial support worker will do to support activities and how the clinical assessment may guide the process. It can be used to guide decision making to engage the consumer and can be found in Appendix 3
  - the process for accepting referrals. Referrals should be accepted either:
    a) verbally during a collaborative clinical or stakeholder meeting and the outcomes written as a part of the clinical documentation by the AHP.
    b) through a written response using an agreed procedure for accepting referrals between agencies.
    c) as a telephone referral.
  - the time frame and process for review, completion and feedback to the HHS MHAOD staff on the community support activities.
  - the process for communicating deviations from the agreed support activity
  - the process for escalating concerns about risks to consumers, staff or others identified during the community support activity.

Review of the community support activities

- A review may be conducted through one or more of the following processes:
  - Inviting the community managed organisation to participate in the HHS MHAOD case review meeting to provide verbal feedback on the delivery and completion of the community support activities.
  - AHP participation in the review cycle of the community managed organisation, which includes reviewing documentation in the clinical record.
  - Written updates provided by the community managed organisation at agreed intervals. The updates will be:
    a) timely, relevant and within the confines of what was agreed upon in the referral process.
    b) provided prior to the agreed time period or review if staff cannot attend the collaborative meeting process.
- The process should include a review of the activity being performed as one part of the AHPs evaluation of the outcomes of the care plan by the AHP. The evaluation should consider the following.
  - whether the referred activity has been undertaken as agreed during the collaborative recovery planning process.
  - the level of support provided to the consumer e.g. activity performed with support, independently or with prompts.
  - any deviations from the planned process to provide the community support activities.
  - time frames for the review/completion of the community support activities.

- A flowchart of the steps in referring for a community support activity are detailed in Figure one.

Figure one: Steps in referring a community support activity



AHP documents and communicates outcomes including

- the progress of the community support activity and any changes to the agreed plan
- completion of the community support activity, including if the desired outcomes were achieved, and any relevant next steps

Documentation

- Where there is not a shared record, there must be a clear documentation process established to support communication between the community managed organisation and the AHP to facilitate safe consumer access to care.
- AHPs are required to utilise the mental health suite of clinical documentation. Documentation should be consistent with the Mental health clinical documentation. User guide 2018 and Guideline for the Use of the Standard suite of clinical documentation 2017; which sets out minimum requirements for the use of mental health clinical documentation. Key clinical documents required for facilitating shared/collaborative care include the Care plan, Case review and Recovery plan
- AHPs will document all relevant information about referrals for community support activities in the consumer's clinical record, ensuring that information is noted as appropriate in the Care Plan, Recovery Plan and Case Review.
- Information to be documented by AHPs includes:
  - the referral and outcome of the referral
  - the type/s of community support activity to be provided, the desired outcomes, and the timeframes for review and completion of the community support activity, as agreed with the consumer and the community managed organisation
  - updates regarding the progress of the community support activity and any changes to the agreed plan
  - completion of the community support activity, including whether or not the desired outcomes were achieved, and any relevant next steps.

Related documents

Legislation, standards, procedures and guidelines

- Mental Health Act 2016(Qld)
- National Standards for Mental Health Services (2010)
- National Safety and Quality Health Service Standards. Second edition (2017)
- Queensland Health Connecting Care to Recovery (2016-2021)
- Queensland Health Guidelines for the use of the standard suite of mental health clinical documentation
- Queensland Health User Guide for the Revised mental health clinical documentation
- Queensland Health Clinical Supervision Guidelines for Mental Health Services
- Code of Conduct for the Queensland Public Service

Relevant documents

- Human Service Quality Framework (HSQF)
- A Framework for Local Implementation and Support of Skill-sharing and Delegation Practice for Allied Health Services in Queensland Public Health System
- Allied Health Assistant Framework
- Calderdale Framework
- Delegation Training Resources
- Guidelines for Skill-sharing Between Allied Health Professionals
- State-wide Mental Health Allied Health Scope of Practice Project Report. Community, Adult Mental Health
- The Allied Health Expanded Scope Strategy (2016-2021)

Version Control

Version	Date	Prepared by	Comments
1	21.03.18	Fiona Hall	Preliminary draft
2	20.05.18	Fiona Hall	Changes following preliminary steering group feedback
3	17.07.18	Fiona Hall	Changes following 27.06.18 steering group meeting
4	09.08.18	Fiona Hall	Changes following 25.07.18 steering group meeting
5	15.10.18	Fiona Hall	Changes following 26.09.18 steering group meeting
6	21.11.18	Fiona Hall	Changes following 23.10.18 reference group meeting
7	04.12.18	Fiona Hall	Changes following 04.12.18 reference group meeting
8	07.07.21	Fiona Hall	Changes following evaluation of the toolkit and feedback by steering and reference groups.

Appendix 1: Consumer support activities

The table below lists frequent consumer support activities. These activities do not involve direct clinical care or clinical decision making and have negligible risk associated with them but may be relevant to clinical care planning by the allied health professional. They are completed by the psychosocial support worker in the community managed organisation.

Consumer and carer engagement and participation support activities	
Activity details	**Activity description**
Facilitate consumer and carer engagement and access	Provide encouragement and support consumer and carers to engage and access health service providers as documented in the consumer recovery plan. Defined activity: • provision of education information to consumer and carers/ family about services provided and how to access them • provision of practical support such as scheduling and confirmation of appointments • provision of service linkages through support with accessing services • provision for motivational support to attend appointments. These activities may include supporting consumer engagement with: • employment • training agencies • education providers • health service providers.
Participation and liaison in stakeholder meetings	Defined activity: • Liaising, preparing and participating in meetings / case review with MHAOD and community managed organisation involved in the provision of community support services to the consumer. • Sharing information to support decisions about service supports required and services to be provided. • Documenting outcomes.
Recovery support	
Activity details	**Activity description**
Recovery support for: • Housing/accommodation support	Support linkages to appropriate local supports including services focused on the maintenance of current housing options where possible, assisting consumers to obtain

	suitable housing if required and providing practical support during any relocation phase.
Recovery support for personal activities of daily living (ADLs): • Establishing a daily routine • Personal grooming • Sleep preparation	Support for safe and efficient ways to carry out ADLs to optimise function. This may involve routines and support that may enhance consumer independence and development of skills.
Recovery support for domestic ADLs: • Shopping • Meal preparation • Food safety and storage	
Recovery support for domestic ADLs: • Doing laundry • Doing cleaning	Support safe and efficient ways to carry out cleaning and laundry to optimise function. This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for instrumental ADLs: • Using public transport • Navigating appointments	Support safe and effective ways to access transport. Research transport options to build and promote consumer independence. This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for instrumental ADLs: • Building independence in managing finances • Budgeting, banking and bill payment • Computer skills	Support safe and effective ways to carry out managing finances, budgeting, banking and bill paying and computer skills to optimise function. This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for: • Mental health strategies	Support safe and effective ways to manage general and mental health. May include: appointment attendance, ‘homework’ from therapeutic programs and regular activities to manage illness e.g. (mindfulness, sensory activities, distraction etc).
Recovery support for healthy lifestyle	Support for safe and effective ways to manage health. May include diet, exercise, substance use (including caffeine, tobacco and alcohol).
Recovery support for social inclusion and community engagement: • Participation in education	This may involve routines and support that enhance consumer independence and development of skills. Support for work readiness to develop the skills set for employment may be included.

• Participation in leisure • Participation in employment	Computer skills to support education, employment and leisure may also be provided e.g. learning to access myGov, foundation level computer skills to navigate the internet and use a personal computer.
Information collection and recording	
Activity details	**Activity description**
Information providing for the social and environment interactions	Collect and record information of consumer social and environmental interactions, potential risks, supports and limitations.
Information providing for personal, domestic and instrumental ADLs	Collect and record information on encouragement and support for consumer personal, domestic and instrumental activities of daily living. Specific examples include: • personal grooming, sleep preparation • domestic ADL including cooking, cleaning, laundry • instrumental ADL including shopping, budgeting, accessing community services and transport. This information provision is based on individual needs and recovery goals and may be based on an ADL assessment or therapeutic remediation of the activities by the occupational therapist. e.g. occupational therapists would often meet with the psychosocial support workers to ask about a consumer function and this information would be included in an occupational therapist report. Occupational therapists may also make recommendations to a consumer (and their psychosocial support worker) on strategies they can use to increase independence (e.g. housework routines, a graded way to catch a bus etc).
Information providing for psychosocial risk	Provide information about the consumer level of functioning within their home environment
Information providing for physical health risk	Provide information about health issues including: • physical signs and symptoms that have been expressed or observed • risk factors including sexual health, oral health, smoking and obesity.
Information providing for mental health and alcohol and other drugs risk	Provide information relating to consumer history through contact in the community support service role. Specific examples include: presenting needs and relevant history, current functioning, relevant cultural and social issues, family and developmental history. This information informs the development of a clinical formulation and recovery management planning.

Appendix 2: Terms for the Local Partnership Agreement (LPA)
Hospital and Health Services and Community Managed Organisations enter into differing agreements that service different functions. Two common types of agreements used between partner services are Service Level Agreements and Local Partnership Agreements.

A Service Level Agreement (SLA) is an agreement between two or more parties, where one is the customer and the others is the service provider. This can be a legally binding formal or an informal "contract". Components can include purchasing of services or funding between services, definitions of services and the arrangements for the termination of agreement. To ensure that SLAs are consistently met, these agreements are often designed with specific lines of demarcation and the parties involved are required to meet regularly to create an open forum for communication. Rewards and penalties applying to the provider are often specified. Most SLAs also leave room for periodic (annual review) revisitation to make changes

Local Partnership Agreements (LPA) are the results of conversations. They articulate the ways in which local partners will work together to streamline service delivery and engage their communities. These agreements provide the opportunity for local partners to determine what strategies will work best for them and the populations they serve. An LPA may include strategies for each of the following:

- Outreach to underserved communities
- Coordination of referral processes
- Inclusion of community partners
- Integration of corresponding person-centered plans
- Communication between partners
- Fidelity to agreements
- Leveraging of resources
- Coordinated and well-sequenced services

Consistent with the overarching principles of the Guideline, Community support activities would be included as part of a collaboratively developed, Local Partnership Agreement or equivalent, between Hospital and Health Service Mental Health Alcohol and Other Drug Service and the Community Managed Organisation. The Local Partnership Agreement would be completed by the service managers or equivalent.

A Local Partnership Agreement, service descriptor for community support activities detailed below, provide an example agreement as they relate to community support activities.

Example of Local Partnership Agreement

Intent/Purpose
The purpose of this collaboration is to foster preparation to facilitate referrals between Community Managed Organisations and Hospital and Health Services

Aims

The service delivery model between xxxxx service and xxxxx service will be:

a) Establish effective, collaborative partnerships with the HHS mental health and alcohol and other drugs (MHAOD) and the Community Managed Organisation.
b) Establish a detailed understanding of local resources for the support of individuals with non-acute mental health problems.
c) Accept and evaluate referrals, consistent with the Guideline for Referring for a Community Support Activity (Guideline).

Your objectives for the xxxxx and xxxxx programs are to:

([<<insert>>] e.g. links to scope of Community Managed Organisations objectives

Principles of effective activity service requests:

- Consumers are supported to develop and maintain social, recreational, occupational and vocational activities which are meaningful to them.
- The primary motivation for referring for community support activities is to serve the best interest of the consumer.
- The allied health professional determines the need for the community support activities in collaboration with the consumer, carers and community managed organisation as part of joint recovery planning and the multidisciplinary team care process.
- Working collaboratively and respectfully with the community managed organisation and partners is fundamental to the success of the Guideline.
- Collaboration with the community managed organisation and review of the consumer's progress toward their recovery goals are an integral part of holistic collaborative care and should inform multidisciplinary care planning and review.

Community support activity referrals
Community support activities provided by the community managed organisation partner, include:

Consumer and carer engagement and participation support activities	
Activity details	**Activity description**
Facilitate consumer and carer engagement and access	Provide encouragement and support consumer and carers to engage and access health service providers as documented in the consumer recovery plan. Defined activity: • provision of education information to consumer and carers / family about services provided and how to access them

	• provision of practical support such as scheduling and confirmation of appointments • provision of service linkages through support with accessing services • provision for motivational support to attend appointments. These activities may include supporting consumer engagement with: • employment • training agencies • education providers • health service providers.
Participation and liaison in stakeholder meetings	Defined activity: • Liaising, preparing and participating in meetings/case reviews with MHAOD and community managed organisation involved in the provision of community support services to the consumer. • Sharing information to support decisions about service supports required and services to be provided. • Documenting outcomes.
Recovery support	
Activity details	**Activity description**
Recovery support for: • Housing/accommodation support	Support linkages to appropriate local supports including services focused on the maintenance of current housing options where possible, assisting consumer to obtain suitable housing if required and providing practical support during any relocation phase.
Recovery support for personal Activities of Daily Living (ADLs): • Establish a daily routine • Personal grooming • Sleep preparation	Support for safe and efficient ways to carry out ADLs to optimise function. This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for domestic ADLs: • Shopping • Meal preparation • Food safety and storage	Support safe and efficient ways of shopping, meal preparation and food storage. This may involve routines and support enhance consumer independence and development of skills.
Recovery support for domestic ADLs:	Support safe and efficient ways to carry out cleaning and laundry to optimise function.

• Doing laundry • Doing cleaning	This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for instrumental ADLs: • Using public transport • Navigating appointments	Support safe and effective ways to access transport. Research transport options to build and promote consumer independence. This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for instrumental ADLs: • Building independence in managing finances • Budgeting, banking and bill payment	Support safe and effective ways to build independence in finances, budgeting, banking and bill payment to optimise function. This may involve routines and support that enhance consumer independence and development of skills.
Recovery support for: • Mental health strategies	Support safe and effective ways to manage general and mental health. May include: appointment attendance, 'homework' from therapeutic programs and regular activities to manage illness e.g. mindfulness, sensory activities, distraction.
Recovery support for healthy lifestyle	Support for safe and effective ways to manage health. May include diet, exercise, substance use including caffeine, tobacco and alcohol.
Recovery support for community engagement: • Participation in education • Participation in leisure • Participation in employment	This may involve routines and support that enhance consumer independence and development of skills. It may include work readiness skills to develop a skill set ready for employment. Support may also include a range of computer skills to support education and employment e.g. skills to access myGov, basic computer skills to navigate the internet and using a personal computer.
Information collection and recording	
Activity details	**Activity description**
Information providing - Social and environment	Collect and record information of consumer social and environmental interactions, potential risks, supports and limitations.
Information providing - Personal, domestic & instrumental ADL	Collect and record information on encouragement and support for consumer personal, domestic and instrumental activities of daily living. Specific examples include: • personal grooming, sleep preparation • domestic ADL including cooking, cleaning, laundry

	• instrumental ADL including shopping, budgeting, accessing community services and transport. This information provision is based on individual needs and recovery goals and may be based on an ADL assessment or therapeutic remediation of the activities by the occupational therapist. e.g. occupational therapists would often meet with the psychosocial support workers to ask about consumer function and this information would be included in an OT report. Occupational therapists may also make recommendations to a consumer (and their psychosocial support worker) on strategies they can use to increase independence e.g. housework routines, a graded way to catch a bus.
Information providing - Psychosocial risk	Provide information about the consumers level of functioning within their home environment
Information providing- Physical health risk	Provide information about health issues including: • physical signs and symptoms that have been expressed or observed • risk factors including sexual health, oral health, smoking and obesity.
Information providing - mental health, alcohol and other drugs risk	Provide information relating to consumers history through contact in the community support service role. Specific examples include presenting needs and relevant history, current functioning, relevant cultural and social issues, family and developmental history. This information informs the development of a clinical formulation and recovery management planning.

Communication between partners

Should there be barriers to fulfilling the community support activity the following escalation process will be followed:

[<<insert>> e.g. If a referred activity has not been completed, the allied health professional is to follow-up and receive feedback from the psychosocial support worker/team leader that accepted the referral. In the event that the referral is not fulfilled in the next scheduled review date this will be escalated to the Community Managed Organisations Service Manager or equivalent.

[<<insert>> Links to organisational risk management policies and procedures

Technical requirements for services

a) Number of referrals
b) Number of referrals enacted
c) Number of shared recovery planning processes
d) Number of shared case reviews.

Qualifications, admissions and memberships

The Partners warrants that they have the following qualifications, admissions and memberships:

[<<insert>>]

Skills transfer

The Partners will use their best endeavours to impart skills to and instruct their employees with a view to increasing and consolidating the skills base

Meeting requirements

The meetings required under this clause are in addition to the meetings required under Agreement.

[<<insert any meeting requirements including location, date and time or frequency, between the Customer and a provider e.g.:>>]

The Partners Authorised Officer will attend the following meetings:

[<<insert>>]

Evaluation requirements

The Partners will give the following service evaluation outcomes:

[<<insert>>]

Appendix 3: Consumer skills development model

The Consumer skills development model is a decision-making tool that provides a common understanding between the allied health professional, psychosocial support worker and consumer of what the psychosocial support worker will do to support activities and how the clinical assessment may guide the process. It can be used to guide decision making to engage the consumer.

Consumers may not have had the opportunity to learn and gain skills or have lost skills areas. Providing community support activities allows consumers to connect into their community and access opportunities they would not ordinarily have and fosters independence.

Supporting consumers to develop or grow their skills in this area requires an understanding of their existing strengths/skill base pertaining to the community support activity to support them to grow in this area. The skill building cycle, providing just the right challenge and providing a hierarchy of support guides skill development tailored for the individual consumer.

Figure 1:Skill development model

Identify individual's strengths – Though conversations identify the individual's current experience and level of expertise pertaining to the specific activity. For example, in accessing public transport:

a) "When was the last time you used public transport (bus/train)?"
b) "How was that experience for you?"

Select an activity – collaborate with the consumer to support their preferences to develop the chosen activity e.g. one that utilises public transport. The activity may include catching the bus to go shopping, accessing an activity in the community or going to the bank.
Supporting practice – Undertake unobtrusive observations when the consumer completes the activity e.g. When catching public transport this may include fare management, navigating bus/train time table, preparing to exit or road safety. Only intervene if there is a health or safety issue or the resident requires prompting.
Problem solving – Provide "just the right" challenge. Allow the consumer an opportunity to complete the activity, however be available to provide support through prompting or demonstration as needed.
Prompting/Demonstration – Using the "Hierarchy of support":

a) Verbal prompt – Use an open-ended question that communicates to the consumer that something is expected but nothing too specific e.g. "What do you need to do next?"
b) Modelling – If the consumer does not respond, model what to say e.g. "If I needed to find the time of the bus I would…..?"
c) Visual/gestural prompt – You can point to information e.g. pointing out the location of the bus timetable, prompting with the go card machine
d) Demonstration – Complete the activity whilst the consumer is observing i.e. buying a paper ticket.

Provide feedback and develop skill development strategies – from the information gained through the process collaborate with the consumer to determine if they have achieved their desired goal, require further support or if a clinical referral is required to provide specialist input.
Review of strategies – If a skill development/recovery support plan is implemented it is to be reviewed.

Restart the Skill Building Cycle Again

Appendix 4: Referral for sub-acute services: Activity plan

Collaboration with community managed organisations and review of consumer led progress toward their recovery goals are an integral part of holistic collaborative care and should inform multidisciplinary care planning and review. The activity plan has been found useful in sub-acute services e.g. step-up step-down units and can be used as part of a handover of community support activities and used between reviews in co-located services.

Activity Plan for week commencing Wednesday: dd/mm/yyyy

Bed	Consumer	Entry info	Activity Plan (From C/R)	Comp. By	Mid-week Activity Requests (Outside C/R)	Comp. By	EED
1	**JOHN CITIZEN, 49yo, txa, BPD, schizophrenia**	Entered yesterday 6/8					
2		Entered 1/8, 6 days ago					
3		Entered 7/8, today					
4		Entered 30/7, 8 days ago					
5		Entered 18/7, 20 days ago					
6		Entered 1/8, 6 days ago					
7		Entered 23/7, 15 days ago					
8		Entered 6/8, yesterday					
9		Entered 1/8, 6 days ago					
10		Entered 5/8, 2 days ago					

- Complete by: tick or cross with staff members initial and date attempted. If a cross, the date the task was attempted and a corresponding CIMHA note detailing why.
  Mid-week Activity Requests: consumer name, clear task, due date and initial of requestor.

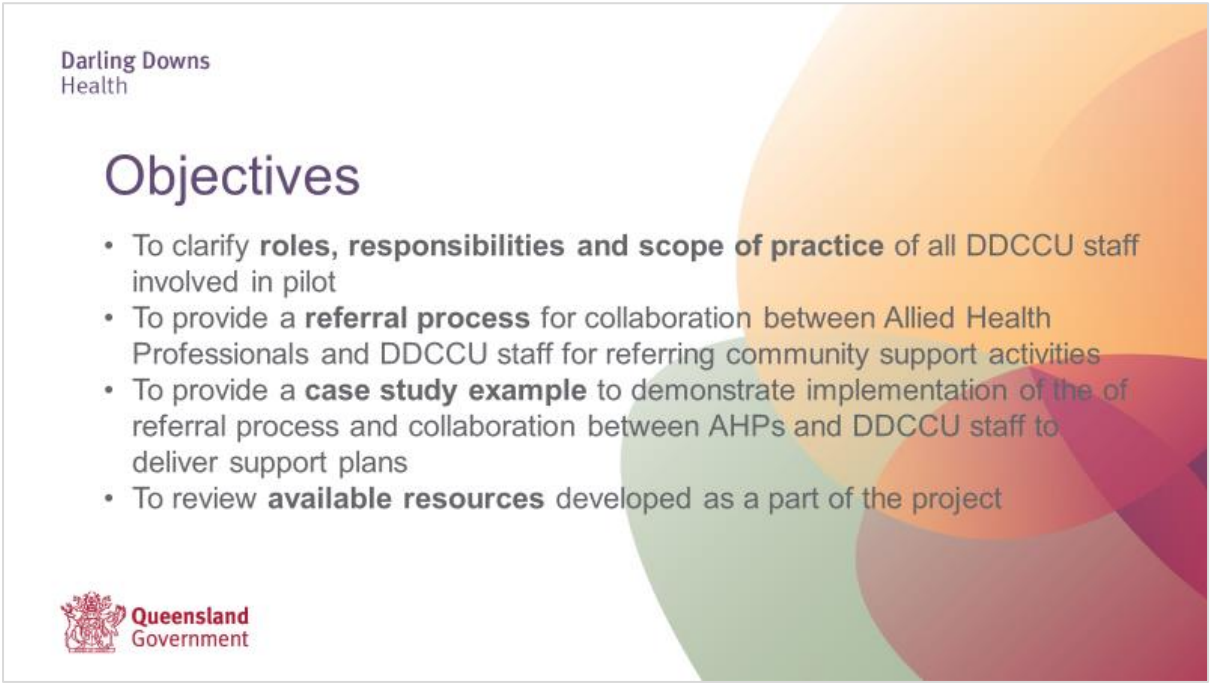
Appendix 5: Referral for long term services: Collaborative Planning and Appointment Support

The template has been found useful in long-term services e.g. community care units or case management teams and can be used as part of a collaborative planning and appointment support tool when referring for a community support activity.

This form can be used by the allied professional as a written referral to the community-managed organisation.

Appendix 6: Darling Downs HHS Implementation site orientation and case study example

Orientation slides, used by the Darling Downs CCU when orientating staff to a Referring for a community support activity, including objectives/purpose of the orientation, description of the multidisciplinary roles and a case study example. The orientation slides could be modified for local use.



Community support activities

Activities that provide support aimed at promoting the development of skills, coping strategies, healthy lifestyle behaviours and support networks to improve a person's personal, social and occupational functioning

In other words, it is the support you offer residents on a daily basis under the guidance of developed treatment and recovery plans

Darling Downs Health

Community support activities

Activities that provide support aimed at promoting the development of skills, coping strategies, healthy lifestyle behaviours and support networks to improve a person's personal, social and occupational functioning

In other words, it is the support you offer residents on a daily basis under the guidance of developed treatment and recovery plans

Darling Downs Health

Role of Allied Health Professionals in Pilot

- Undertake **discipline-specific assessments** to identify the resident's abilities and support needs to inform rehabilitation recommendations including referrals for community support activities
- Lead the development of **individualised rehabilitation programs and intervention plans** to assist residents to build their skills, focus on their recovery and achieve realistic goals across various areas of daily living
- Continue to **review and adapt intervention plans** and collaborate with DDCCU staff to provide ongoing support and advice

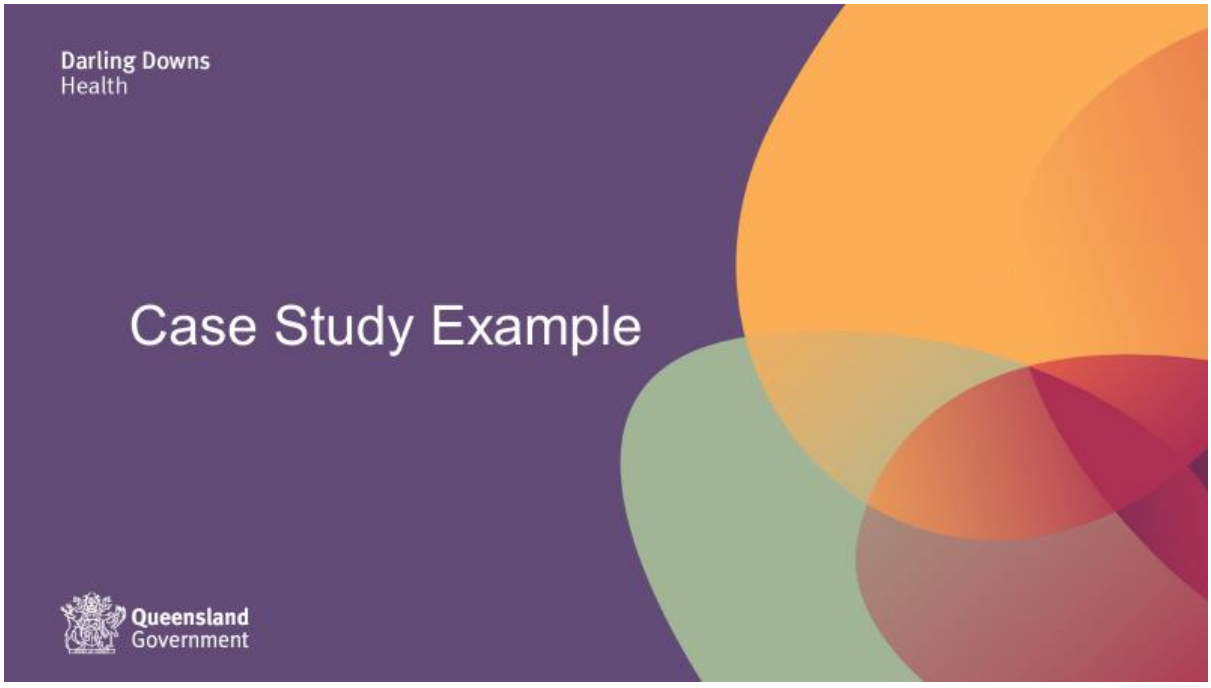
Darling Downs Health

Role of DDCCU Staff in Pilot

- Collaborate with allied health professionals to tailor and optimise supports provided to residents **to guide and enable skill and capacity development** across various areas of daily living
- Support the delivery of individualised rehabilitation programs under the guidance and advice from allied health professionals using **referrals for community support activities**
- Provide **feedback on the resident's progress, participation and performance** during community support activities with scheduled reviews with the allied health professional to evaluate the effectiveness of intervention plans

Darling Downs Health


Referring for a Community Support Activity at DDCCU
Please refer to printed flowchart outlining referral process
Allied Health assessment completed to identify abilities and support needs
AHP to present assessment results and plan for referral for community support activity
Collaborative discussion with DDCCU staff member and resident outlining support plan
Delivery of support plan and use of strategies recommended by AHP
Review to evaluate effectiveness of the support plan and resident's progress
Darling Downs Health


Darling Downs Health
Case Study Example
Queensland Government

Anthony is a 35-year-old man with Schizophrenia who has resided in Toowoomba for the past 7 years. Having recently been admitted to the Community Care Unit, Anthony has identified the following goals:

1. Learn occupational skills such a financial management, cooking, grocery shopping, cleaning and self-care that will assist in being able to live independently.
2. Learn psychological coping strategies, to assist managing mental health, that will allow for greater employment opportunities.
3. Aim to improve physical health (following weight gain of 26kg in past 5 months), physical activity and fitness.
4. Return to social football (soccer) and create some meaningful social connections.

Consumer is provided with Ex Phys Information Pack for Consumers (See Print Out)

Darling Downs Health

Queensland Government

The following Exercise Physiology Assessments were completed, and accompanying measures were recorded as a means of tracking change that are of relevance to goals 1, 3 & 4.

See Print Out: *Types of Assessments* for explanations.

Name of Measure	Initial Ax 01 / 04 / 2020
SIMPAQ (mins)	100
Weighted PA	100
6MWD (m)	380
Height (m)	1.78
Weight (kg)	100.7
BMI (kg/m²)	31.8
Waist (cm)	105
Hip (cm)	100
Pain Scale	-
BREQ-2	-
PANAS	Positive Affect = 20/50 Negative Affect = 39/50
PSFS	-

Darling Downs Health

Queensland Government

Anthony identified the following Costs, Benefits and Motivators with regards to Exercise and Physical Activity.

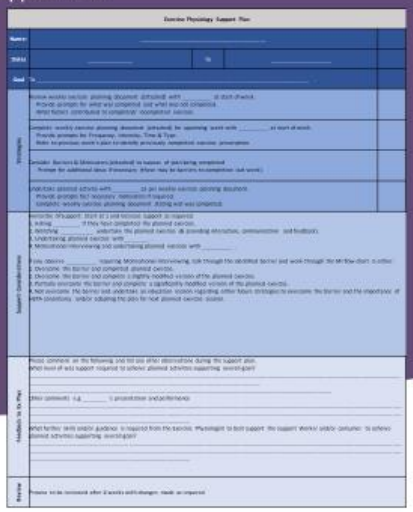
Short & Long-Term Costs	•Short Term Costs - Time, Energy, Sweating, Body Image Concerns •Long Term Costs - Time, Energy, Sweating, More Planning, Increased Intensity
Short & Long-Term Benefits	•Short Term Benefits - Less Boredom, Less Depression, Increased CRF •Long Term Benefits - Improved mHealth, Reduced Fat Mass & Waist, Improved work capability
Short & Long-Term Motivators	•Short Term Motivators - S-T Goals, Making a Habit, Reason for coming to CCU, ^ EP Support, Rewards •Long Term Motivators - Part of recovery, Improving self-efficacy, L-T Goals

Darling Downs Health

Queensland Government

Anthony commences Ex Phys interventions and organises a time with EP & Support Worker to work through Ep Intervention Plan – For Support

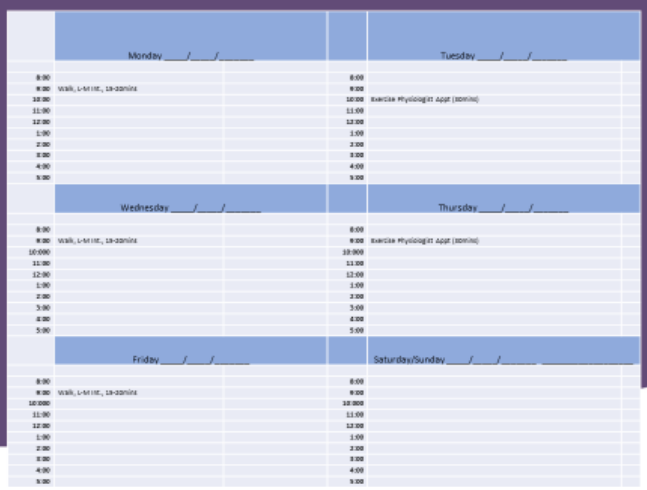
See Print Out: *Exercise Physiology Support Plan*



Darling Downs Health

Queensland Government

Anthony identified the following Weekly Exercise Plan for what he identifies as a manageable start to exercise 2 weeks.



Darling Downs Health

Queensland Government

The Exercise Physiologist identifies the following progressions provided normal recovery and no adverse events are reported.

- Self-Managed (or Support Worker Supported)
  - Walking increased intensity or duration increased by no more than 10%.
- EP consultation/s
  - Increased volume or
  - Increased intensity or
  - Reduced rest breaks (time or frequency)

This process can be continued toward 6 weekly review date at which re-assessment can take place which typically would involve:

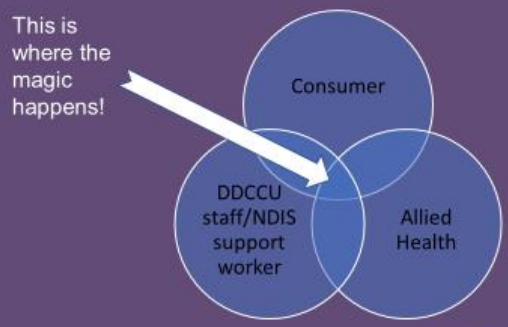
- Remeasure of assessments completed at initial consultation.
- Review of attendance to EP consultations.
- Review of compliance with Self-Managed (and/or supported) exercise.
- Comparison of change in accordance with consumer's stated goals.

Darling Downs Health

Queensland Government

Communication is key!

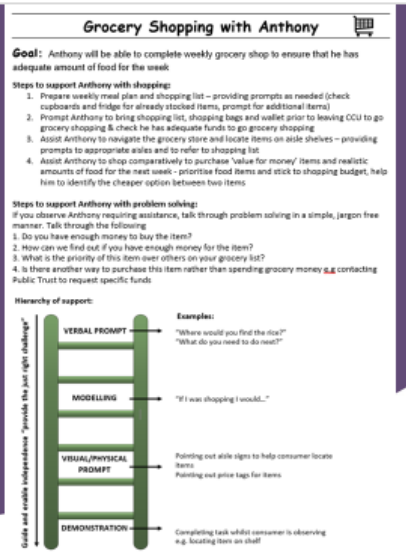
In this particular instance communication is a 3-way street!



Darling Downs Health

Queensland Government

1. Occupational Therapy Assessment was completed. Challenges were identified across areas of daily living including grocery shopping. Anthony identified his **goal of completing weekly grocery shop to ensure he has adequate amount of food for the week.**
2. Assessment recommendations include a referral for community support activity of grocery shopping.
3. OT meets with NDIS support coordinator and support workers to discuss support plan including strategies to support Anthony with grocery shopping and hierarchy of support to guide and enable independence.
4. Review in 4 weeks to evaluate effectiveness of support plan, progress towards achieving goal and to discuss feedback



Grocery Shopping with Anthony

Goal: Anthony will be able to complete weekly grocery shop to ensure that he has adequate amount of food for the week

Steps to support Anthony with shopping:

1. Prepare weekly meal plan and shopping list – providing prompts as needed (check cupboards and fridge for already stocked items, prompt for additional items)
2. Prompt Anthony to bring shopping list, shopping bags and wallet prior to leaving CCU to go grocery shopping & check he has adequate funds to go grocery shopping
3. Assist Anthony to navigate the grocery store and locate items on aisle shelves – providing prompts to appropriate aisles and to refer to shopping list
4. Assist Anthony to shop comparatively to purchase 'value for money' items and realistic amounts of food for the next week - prioritise food items and stick to shopping budget, help him to identify the cheaper option between two items

Steps to support Anthony with problem solving:

If you observe Anthony requiring assistance, talk through problem solving in a simple, jargon free manner. Talk through the following

1. Do you have enough money to buy the item?
2. How can we find out if you have enough money for the item?
3. What is the priority of this item over others on your grocery list?
4. Is there another way to purchase this item rather than spending grocery money e.g contacting Public Trust to request specific funds

Hierarchy of support:

Guide and enable independence "provide the just right challenge"

VERBAL PROMPT — Examples: "Where would you find the rice?" "What do you need to do next?"

MODELLING — "If I was shopping I would..."

VISUAL/PHYSICAL PROMPT — Pointing out aisle signs to help consumer locate items; Pointing out price tags for items

DEMONSTRATION — Completing task whilst consumer is observing e.g. locating item on shelf

See Print Out: *Grocery Shopping with Anthony*

Darling Downs Health

Queensland Government

Pilot Resources

Referring for a Community Support Activity in Mental Health Services Toolkit:

- Guideline and implementation resources
- Companion orientation manual of community treatment and community support tools

Darling Downs Health

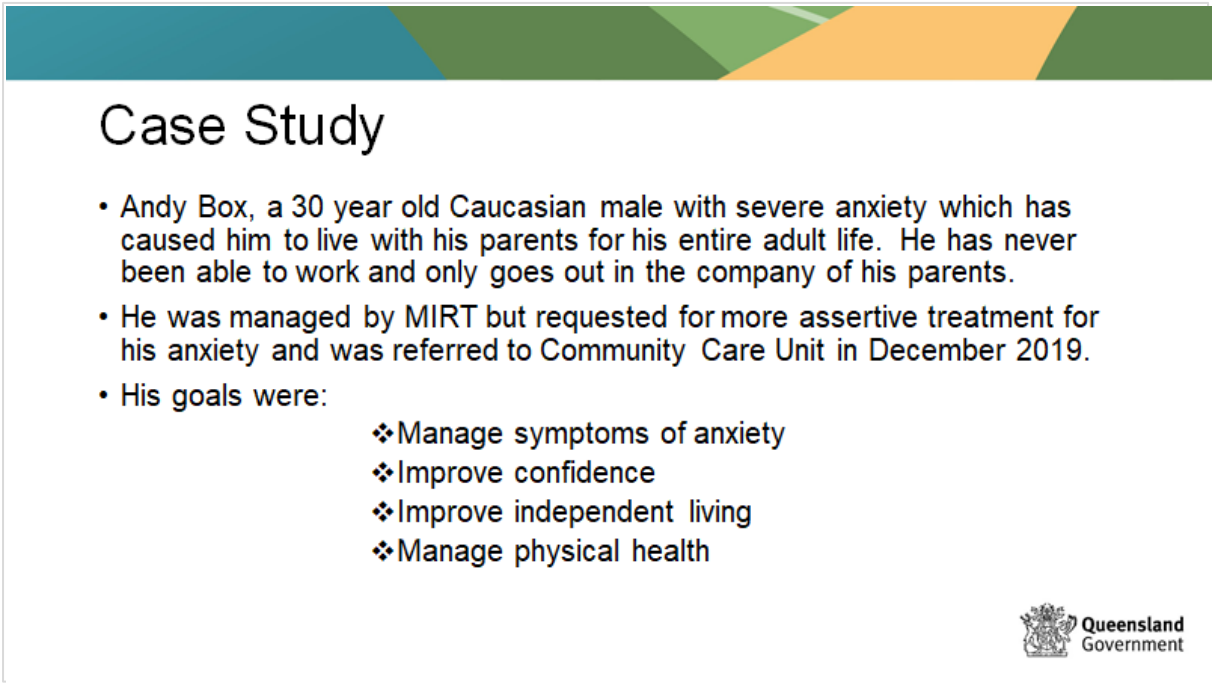
Thank you

For further information and ongoing support please speak with members of the Allied Health team at DDCCU

Darling Downs Health

Appendix 7: Cairns HHS case study example

A case study example of the implementing the guideline in the Cairns Community Care Unit (CCU).



Assessments

Psychological Screen

– Non-standardised screening tool

- High levels of Social Anxiety
- Gaze perception abnormalities
- Poor Self-confidence
- Physical Health/ Dietary improvements

Queensland Government

Assessments

- Dietitian Assessment
  - Weight 58.1 kg
  - BMI 18.1 (ideal range 20-25)
  - Cholesterol – raised cholesterol related to snacks that are high in saturated fat
  - Diet history – only eat one meal a day e.g., tin baked beans on toast, tin ravioli, minimal dairy and vegetables or fruits
- Nutrition Diagnosis – ongoing diet lacking in core food groups in particular dairy, fruit and vegetables.
- Minimal knowledge of food storage e.g. chicken sitting in fridge for days

Queensland Government

Assessments

- Nursing
  - Weekly MSE
  - Metabolic screening
  - Test Pathology – Low Vitamin D Levels
  - Risk assessment
  - Sleep hygiene
  - Medication management/routine
  - Reinforcing routines e.g. Wake up prompts, daily exercise prompts

Queensland Government

Assessments

- Occupational Therapy –

Non-standardised screen – limited skills with

  - Meal preparation
  - Grocery shopping – dependent on parents
  - Laundry
  - Walking and climbing stairs
  - Community Access skills
  - Community connection
  - Structured routine

Queensland Government

Assessments

- Occupational Therapy Standardised Assessments
  - ❖Occupational Self Assessment - OSA
  - ❖Allen Cognitive Level Screen – ACLS
  - ❖Kawa Model

Queensland Government

RCAiMHS referral for the following

Community Activity	RCAiMHS intervention	Achieved Outcomes
Reduction in social anxiety	Graded exposure activities in the community Support to attend Recovery College Explore voluntary work Explore alternative independent transport options as severe anxiety with public transport	Increased participation in graded exposure activity. Reduction in avoidant behaviour. Participate in Anxiety workgroup Volunteers at Botanical Gardens Uses a bicycle to get to places and appointments
Meal preparation	Supports with meal preparation – using kitchen utensils and skills development in food preparation. Attends Food and Mood dietician group	Independent with basic meal preparation activities. More variety in diet. Vitamin D levels is back to normal. Positive weight gain -58kg to 67 kg
Daily ADLs	Support with skills development Support to develop and maintain a daily structured routine Develop positive sleep hygiene patterns	Occasional verbal prompts require especially with upkeep of unit. Maintains positive sleep hygiene patterns especially since he started volunteer work

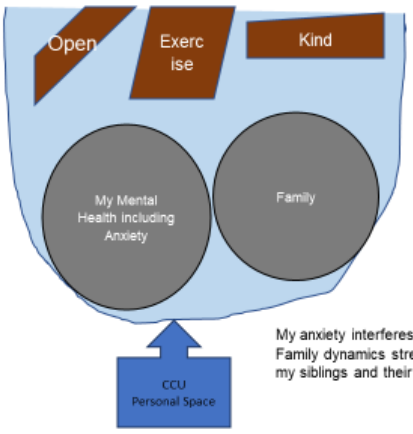
Queensland Government

OSA Results Pre and Post – Andy Box Self Assessment

Activity	Pre	Post
Getting where I need to go	I have some difficulty	I do this well and this is important to me
Managing my basic needs	I have some difficulty	I do this well and this is very important to me
Identifying and solving problems	I have some difficulty	I do this well and this is important to me
Having a satisfying routine	I have some difficulty	I do this well but this is not so important to me
Being involved as a volunteer or family member	I have some difficulty	I do this well and this is important to me
Doing activities I like	I have some difficulty	I do this well and this is very important to me

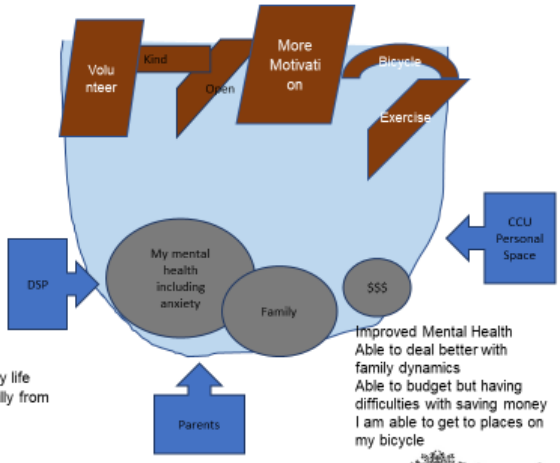
Queensland Government

Kawa Model Pre RCAiMHS



My anxiety interferes with all aspects of my life
Family dynamics stressed me out especially from my siblings and their extended families

Kawa Model post RCAiMHS



Improved Mental Health
Able to deal better with family dynamics
Able to budget but having difficulties with saving money
I am able to get to places on my bicycle

Queensland Government

Assessment post measures

- 3 monthly review and weekly updates at MDT meeting
- Outcomes
  - HONOS
  - LSP

Queensland Government

Lessons we have learnt

- Prioritize the referrals in terms of importance to the resident
- Better outcomes if the activities referred are of valued to resident
- Not too many referrals at one time
- Better outcomes if there is one keyworker for consistency and continuity

Queensland Government

Thank you

Support worker who did all the magic with Andy Box– Naomi Evans - MIND
RCAiMHS Champion – Zebb Moody, MIND
Sean Devine – Psychologist, Qhealth
Lisa Mercer – Dietician, Qhealth
Nancy Ong – Occupational Therapist, Qhealth
Chris Holland – Clinical Nurse, Qhealth
.....A concerted team effort from Cairns Community Care Unit

Queensland Government

References

- Queensland Health (2017). Queensland Health, Mental Health Alcohol and Other Drug Workforce Development Plan, 2016-2021). https://qheps.health.qld.gov.au/__data/assets/pdf_file/0033/1955409/mhaod_workforce_dev_framework.pdf
- Queensland Health b (2017). Statewide Mental Health Allied Health Scope of Practice Project Report. Community, Adult Mental Health https://www.health.qld.gov.au/__data/assets/pdf_file/0044/649997/mhahsp-project-final-report.pdf
- Queensland Health c (2017). Advancing health service delivery through workforce – A strategy for Queensland 2016-2026 https://www.health.qld.gov.au/__data/assets/pdf_file/0039/657993/QH959-advancing-health-service-workforce.pdf
- Queensland Health (2016) Connecting Care to Recovery1 and My health, Queensland's future: Advancing health 2026 https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf
- Queensland Health b (2016) Allied Health, Expanded Scope Strategy 2016-2017 https://www.health.qld.gov.au/__data/assets/pdf_file/0024/449520/expanded-strategy.pdf