Queensland Health

Referring for a community support activity: A model and toolkit that enhances collaborative partnerships and mental health clinical full scope of practice

Allied Health Professions' Office of Queensland

A partnership with Neami National and Mind Australia

Cairns, Metro North, West Moreton and Darling Downs Hospital and Health Services

Neami National
Improving Mental Health and Wellbeing

mind
Supporting mental health recovery

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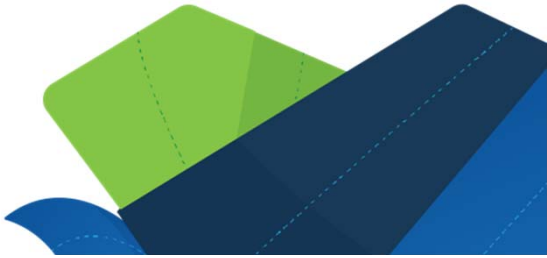
Overview to the presentation

- Describe the Referring for a Community Support Model Project in Mental Health Services
- Implementation in two different service settings, Toowoomba Community Care Unit (CCU), Darling Downs Health and *Nundah House (Alternatives To hospital facility)*
- Evaluation findings
- Next steps in the spread and scale of the model



Background to the model development

- Co-designed initiative
- Partnership models with community managed organisations to support recovery
- Opportunities for allied health to optimise their scope of practice
- Lack of clarity around processes, governance, roles and responsibilities.

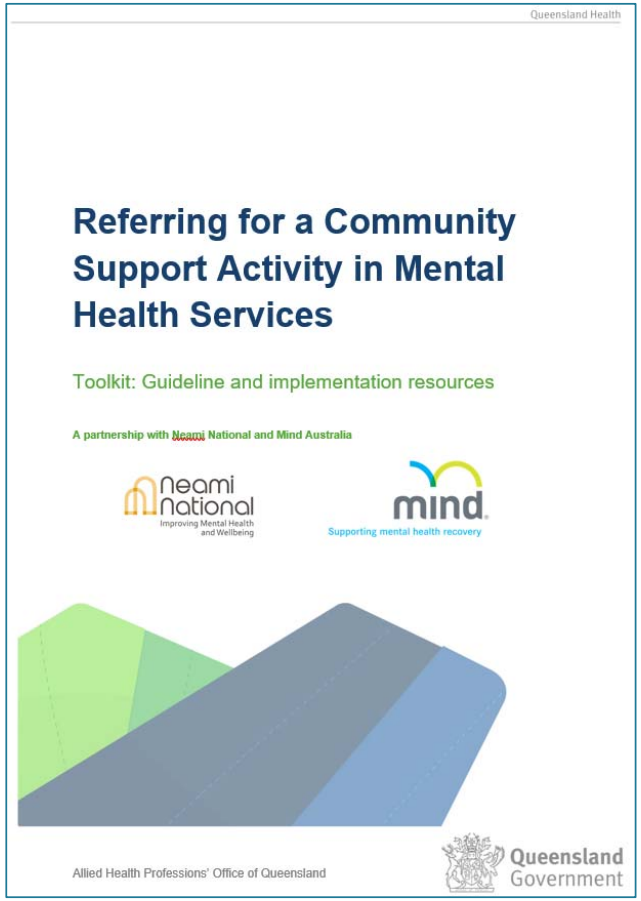
Overview of the project model

Formalise referral processes of psychosocial supports

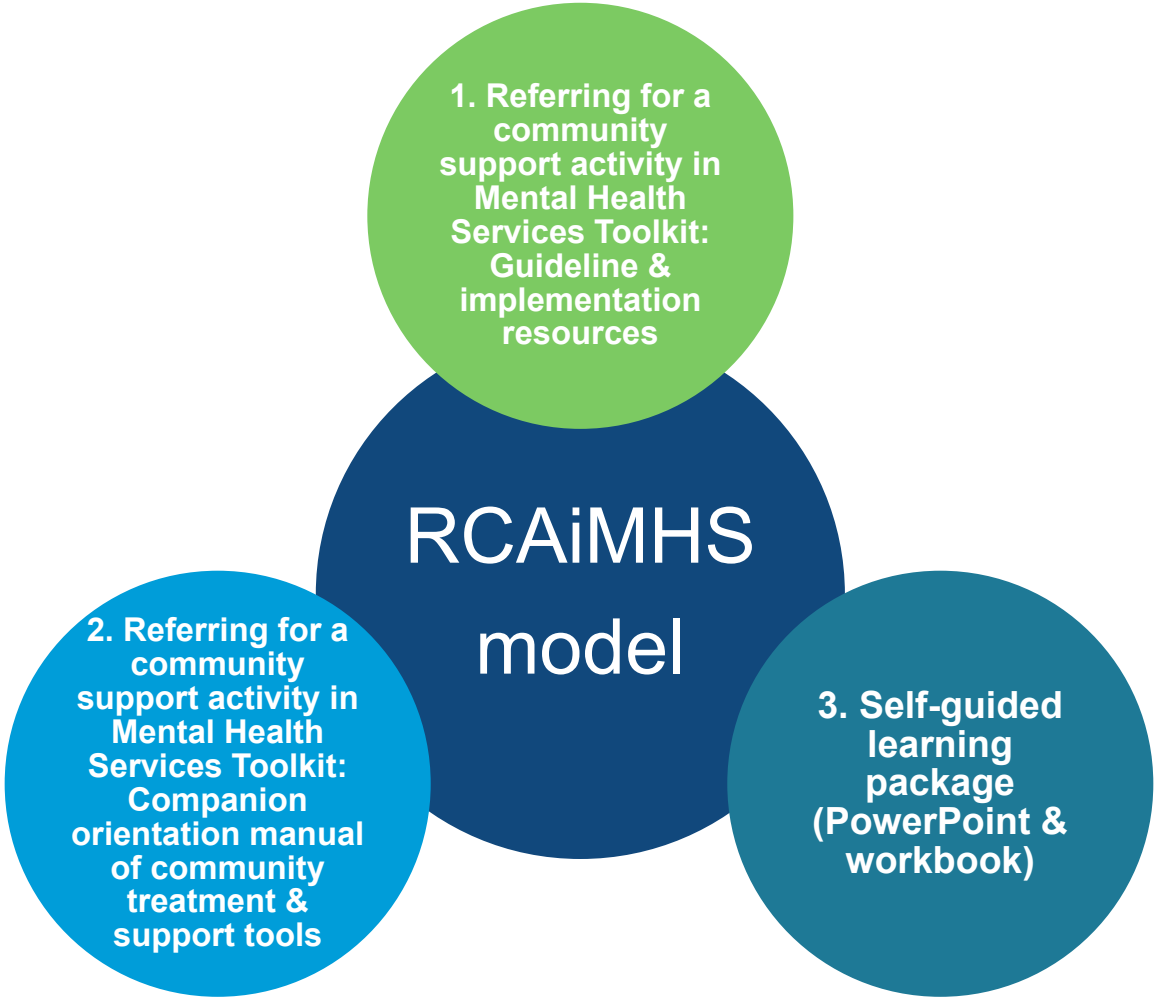
Development of a toolkit that aimed to support staff to:

- Understand processes, governance, roles responsibilities
- Understand the scope of practice of all staff involved
- Enhance collaboration and teamwork.

Developing the toolkit



The toolkit


1. Referring for a community support activity in Mental Health Services Toolkit: Guideline & implementation resources
RCAiMHS model
2. Referring for a community support activity in Mental Health Services Toolkit: Companion orientation manual of community treatment & support tools
3. Self-guided learning package (PowerPoint & workbook)

Implementation

- Nundah House (Step Up / Step Down short stay facility), Metro North HHS
- Gailes Community Care Unit (CCU), West Moreton Health (WMH)
- Cairns Community Care Unit (CCU), Cairns HHS
- Toowoomba Community Care Unit (CCU), Darling Downs Health

Darling Downs
Health

Referring for a Community Support Activity in Mental Health

Darling Downs Community Care Unit Queensland Health with Mind Australia

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Purpose

- To **optimise supports** provided to consumers based on their identified strengths, challenges and support needs to help them achieve their recovery goals
- To **maximise opportunities** to engage the consumer in targeted rehabilitation activities
- To **enhance collaboration** between Allied Health Professionals and DDCCU staff in supporting residents rehabilitation and recovery

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Objectives

- To clarify **roles, responsibilities and scope of practice** of all DDCCU staff involved in pilot
- To improve the communication and collaboration between CCU staff
- To increase service efficiency resulting in more consistent and quality rehabilitation
- To provide a **referral process** for collaboration between Allied Health Professionals and DDCCU staff for referring community support activities
- To review **available resources** developed as a part of the project

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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

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Referring for a Community Support Activity at DDCCU

Please refer to printed flowchart outlining referral process

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Case Study Example

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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.

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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.

Name of Measure	Initial Ax 01 / 04 / 2020
SIMPAQ (mins)	100
Weighted PA	100
6MWD (m)	330
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	-

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

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

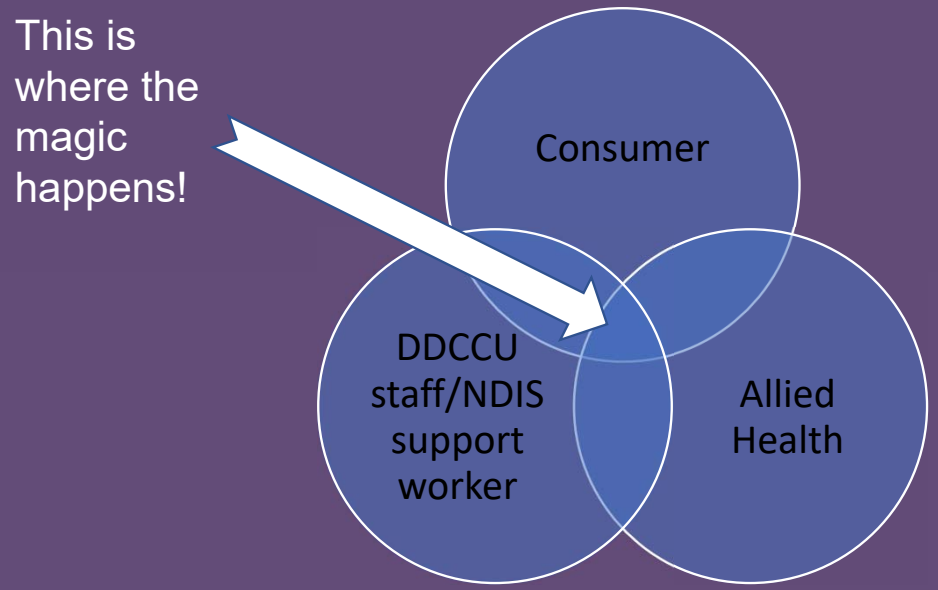
- Self-Managed (or Support Worker Supported)
  - Walking increased intensity or duration increased by no more than 10%.
- EP consultation/s
  - Increased volume or
  - Increased intensity or
  - Reduced rest breaks (time or frequency)

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.

Communication is key!

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



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 Mind Psychosocial support worker and consumer to discuss support plan including strategies to support Anthony with grocery shopping and hierarchy of support to guide and enable independence.

4. Review in 2 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:

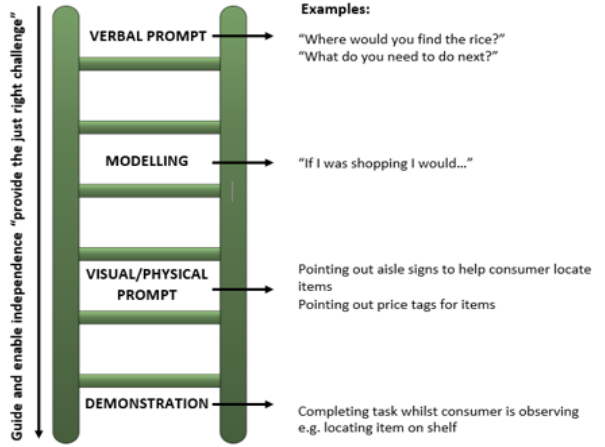
1. Prepare weekly meal plan and shopping list – providing prompts as needed (check cupboards and fridge for already stocked items, prompt for additional items)
2. Prompt Anthony to bring shopping list, shopping bags and wallet prior to leaving CCU to go grocery shopping & check he has adequate funds 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:



See Print Out: *Grocery Shopping with Anthony*

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Benefits of improved collaboration

Improved consumer outcomes
Reduced duplication
Smooth transition into independent living with or without support
We developed a more individualised structure using a similar model utilising NDIS supports
Collaboration was transferrable to NDIS funded supports

Thank you

For further information and ongoing support please speak with members of the CCU Team

Occupational Therapists ellie.lindenberg@health.qld.gov.au; rebekah.lewis@health.qld.gov.au

Exercise Physiologist alastair.mcgorm@health.qld.gov.au

Social Worker kate.stenhouse@health.qld.gov.au

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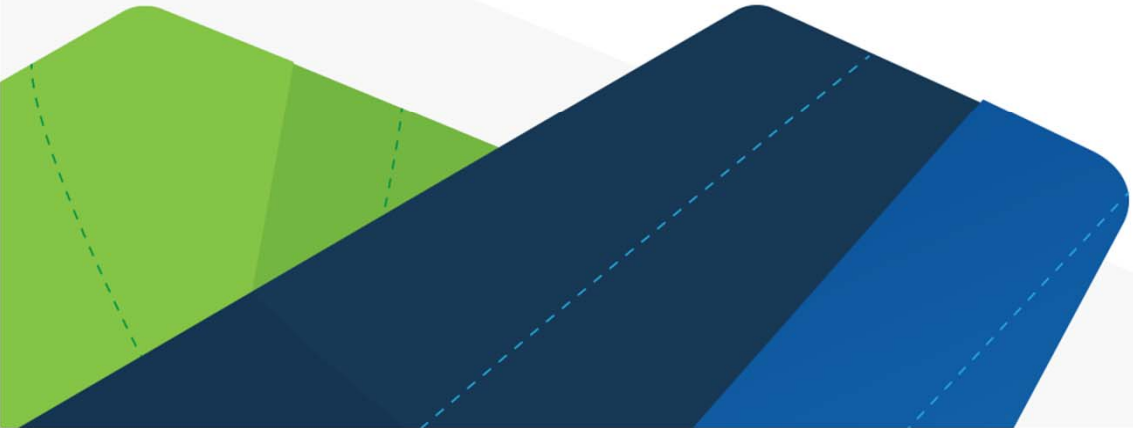
Nundah House Alternative to Admission

Metro Nth HHS and Neami National



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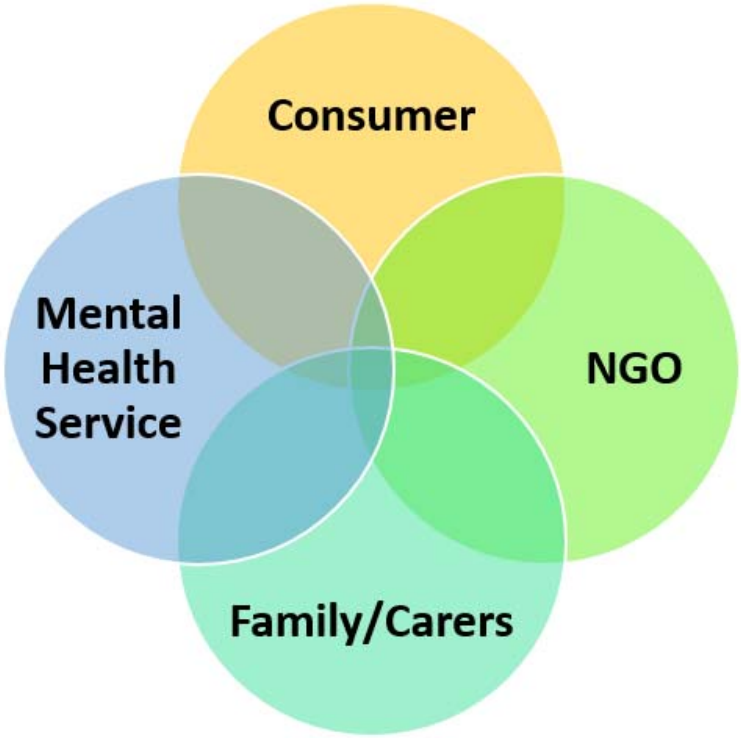
Nundah House

Project Involvement

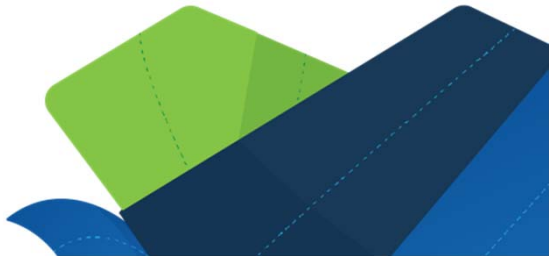
- QH and NN involved from first year of Nundah House, we are a collocated site.
- Collaborative partnership model
- Both teams have been involved in focus groups and information sessions.



Alternative to Admission – Unique Setting and Supports

- Residential setting
- 24/7 service
- Partnered with NGO

Short term stays – 14 day LOS / 200yr
Less focus on rehabilitation; More focus on brief interventions and community linkages for longer term support
Focus on crisis and immediate needs (e.g. sleep hygiene, housing, peer groups)
BUT… often people lack core skills



Communication, Handover and Accountability (App4)

- Primary communication tool trialed and revamped
- Completed weekly at care review (Mid week tasks)
- Two way referral process
- NN Manager and QH Team Leader review
- Either team or individuals *can* be held accountable for not completing tasks
- Priorities change…handovers

Example

Bed	Consumer	Recent info	Plan Ahead (Who is responsible)	EED
#	Name MHA Status Age Diagnosis	Entry date Presenting issues Progress during stay/over last week and interventions provided	Planned interventions (person/role assigned) Monitoring required	Estimated Exit Date

Secondary implementation – Orientation, Education

- Toolkit shared with new employees with varying levels of response; largely dependent on work history and experience
- Adds some theoretical framework to other staff
- Opportunity to review document or parts of the document either within NN, within QH or between teams – either in supervision or generally in team training days

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Referring for Community Support Activities in Mental Health Project Evaluation Findings

Service Evaluation and Research Unit (SERU)

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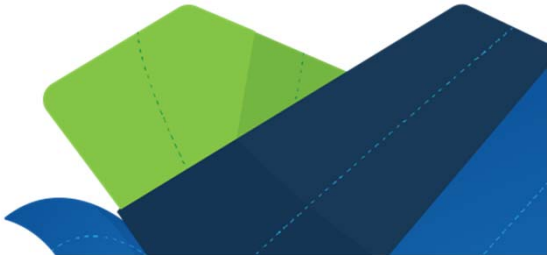
Methodology

- 4 implementation sites

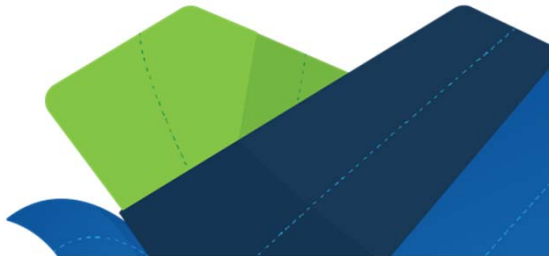
- Approaches:
  - Focus Groups
    - 8 pre implementation (QH & CMO staff)
    - 6 post implementation (QH & CMO staff)
  - Survey

- Staff perceptions of:
  - referral processes, facilitators & barriers
  - RCSAiMH Toolkit and implementation resources



Findings: Pre Implementation

- Some documentation already in use, typically completed by one organisation which is then shared with the other
- Referrals currently not a formalised process – mostly verbally based and facilitated via shared meetings or conversation between staff. Some use of email or handwritten notes / document printouts
- Use of 2 clinical information systems duplicates / hampers communication and information sharing
- Communication concerns around referral feedback loop for both organisations in terms of expectations, clarification and accountability:
  - Who makes referral for what task and what exactly is required
  - Who reports back on progress, what is reported and to whom
  - How feedback is documented as well as agreed follow up actions



Findings: Post Implementation

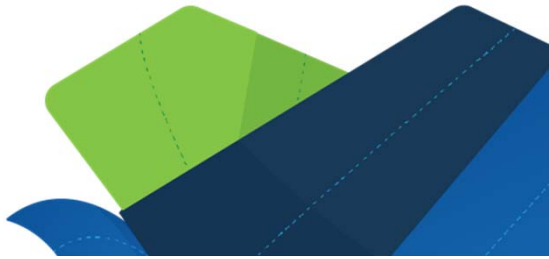
- More formalised process for referrals and feedback developed and currently being implemented, adapted to fit local context, needs and constraints

- Shared access to CIMHA some benefits in terms of communication and information sharing, but not a complete solution:
  - Duplication of information for CMOs
  - Location specific consumer information difficult, still some reliance on hard copy documentation

- Greater understanding around roles / responsibilities and alignment for working collaboratively to achieve consumer recovery goals – still some gaps in expectations what needs to be done to achieve this

Influencing Factors

- Partnership arrangement:
  - duration, relationship, expectations, perceptions
- Workforce:
  - funding
  - stability / turnover
  - rostering / availability / access
  - workload
- Organisational support
- Perceived differences in philosophy (rehabilitation vs recovery)
- Nature of service
- Client suitability / willingness
- Covid

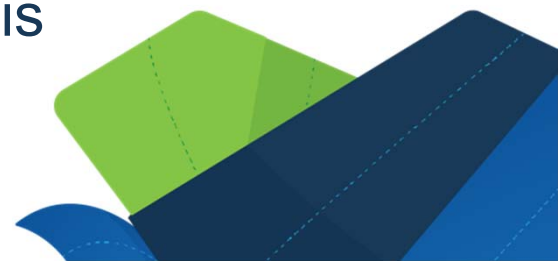


Next steps: Recommendations

- **Recommendation 1:** The Referring for a Community Support Activity Model could be considered for implementation as an integrated service and workforce model in adult Mental Health Alcohol and Other Drug Services with Community Managed Organisation partner services**.**

- **Recommendation 2:** The scope of the model could be expanded to all clinicians and other mental health and alcohol and other drugs services who work in partnership with Community Managed Organisations

- **Recommendation 3:** A project dissemination strategy is implemented



Next steps: Resources

- Resources published at https://qheps.health.qld.gov.au/alliedhealth/html/mental-health
- Further questions on the implementation contact relevant speakers
- Questions?