State-wide Mental Health Allied Health Scope of Practice Project Report

Community Adult Mental Health

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Queensland Government

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Acknowledgements

This project is the culmination of the support and effort of many contributors including:

The Community mental health team members, site coordinator(s) and leadership team at Gold Coast, West Moreton, Darling Downs and Cairns hospital and health services (HHSs).

The community mental health team members and management at Metro North HHS, Metro South HHS, Central Queensland HHS and Sunshine Coast HHS who participated in the external team task review validation.

Members of the project reference group and Steering Committee. The senior mental health clinicians from Queensland Health and academics from the university sector who participated in the Allied Health Expert Review.

Summary

The State-wide Mental Health Allied Health Scope of Practice Project (the project) was undertaken to identify the current scope of practice of allied health professionals working in Adult Community Mental Health Services and identify opportunities to expand scope of practice to improve client outcomes.

The project identified tasks undertaken by the mental health allied health community workforce using the Calderdale Framework, a task analysis methodology. Tasks were categorised as:

- Profession specific tasks for occupational therapy, psychology, and social work including shared practice tasks that are in the scope of more than one profession.
- Opportunities for skill sharing tasks that are currently in scope of one profession, but may be appropriate and safe to skill share assuming training, supervision and clinical governance processes are in place.
- Professional tasks that may be delegated or provided by other workers or other service providers, assuming training, support/ supervision and clinical governance processes are in place.

The project was conducted from April 2016 to November 2016. Sponsorship and funding support for the project was provided by the Allied Health Professions' Office of Queensland (AHPOQ). A project manager was funded 0.6 FTE for this period of time. Community teams in four (4) Hospital and Health Services were selected to participate and provided with training and $10,000 in funding. Participating teams included:

- Mobile Intensive Rehabilitation Team (MIRT) – Cairns and Hinterland HHS
- Continuing Care Teams (CCT) 1 and 2 – Darling Downs HHS
- CCT – Gold Coast HHS
- CCT – West Moreton HHS

Training in the Calderdale Framework was provided to the project facilitators at each site. The sites were to submit their task analysis and final report by 22 July 2016.

Two separate validation activities, an External Team Task Review and Allied Health Expert Review Group, ran concurrently in relation to the preliminary aggregated task list.

Key findings

Analysis of the project data revealed five key findings.

Profession scope of practice is influenced by case management service delivery model and localised context

The difficulties of the adult community mental health workforce to conceptualise and provide concrete descriptions of the range and scope of tasks performed were demonstrated. Although the aggregated task list was reflective of the functional and clinical area elements expected within the scope of the occupational therapy, psychology, and social work professions, it is not exhaustive with external and expert review findings identifying some areas of deficit.

Difficulties can be attributed to the localised context of project sites including: differences in service model(s) and associated scope of practice; service demands and workforce models and capacity.

Clinical service delivery is weighted to assessment and care coordination functions

The findings of the project site task mapping and analysis activities and the task list review activities align with outcomes from a previous project (Community mental health services in Queensland time and motion study, Queensland Health, 2015) in relation to the strong focus of mental health allied health services on generic tasks. These include standardised assessment, risk identification and mitigation and coordination of care. Profession specific and complex assessments and therapeutic interventions are limited due to the constraints of the care coordination functions.

The development of key performance indicators that align with current evidence based practice guidance may also support increased provision of therapeutic interventions.

Multi-professional delivery of clinical tasks is common practice

The project demonstrated a high level of multi-professional delivery of clinical tasks between the occupational therapy, psychology and social work professions. These common tasks represent either shared practice or skill sharing. Shared practice refers to clinical tasks that are in the accepted and documented scope of more than one profession. Skill sharing is implemented as a locally agreed and governed process involving individual positions and health professionals delivering tasks that traditionally sit outside the scope of the profession, where training, supervision and clinical governance processes are in place to support the model.

It is difficult to definitively identify the relative mix of skill sharing and shared practice tasks. A proportion of tasks either aligned with generic capabilities / practice standards for the mental health workforce (such as mental health capacity, mental state and risk) or as key functions within the case manager role that exists within community mental health practice (coordinating treatment and referrals). These are likely to be shared practice tasks.

Remaining tasks identified as being multi-professional in delivery could be attributed to the sharing of these clinical skills at project sites between professions. Some of the tasks within this grouping sat outside the accepted or traditional scope of practice of the professions involved in their delivery. It is however beyond the scope of this project to ascertain whether the skill sharing of these tasks at the local level is the result of a formal teaching and competency assessment process between the professions involved or other factors such as local workforce or workload issues, service needs or service delivery models.

There is varied understanding of the skill share and shared practice concepts and associated practice models

The project demonstrated considerable variation in the understanding within the workforce with regard to the constructs of shared practice and skill sharing, despite the high number of clinical tasks being performed by more than one profession. That no clinical tasks were identified in the project site data as being suitable for skill sharing with other professions suggest that sites had difficulty in being able to discriminate between these concepts within every day clinical practice. This has important implications around the level of risk within service provision, especially in relation to those tasks that sit outside the traditional profession scope and require appropriate training, supervision and clinical governance.

There is varied understanding of the delegation and assign concepts and associated practice models

The project demonstrated considerable variation in the understanding within the workforce with regard to the construct of delegated practice including accountabilities and responsibilities, the process of delegation, the scope of practice of a clinical support worker (e.g. allied health assistant) in relation to mental health services. This impacted upon the consistency and validity of decision making on delegation tasks in local site data collection and analysis activities.

Further emphasis on training to improve understanding around delegated practice, including development of specific training materials is indicated for mental health

Assigning tasks to non-clinical support workers was defined in the project but further work is required to detail and embed this understanding. Issues with understanding were apparent in a small number of local site decisions to assign tasks with clinical knowledge and skill to non-clinical support workers.

Recommendations

The recommendations for future actions are linked to the key project findings and include:

- Review of the model of service delivery within adult community mental health services in line with the current national and state based mental health strategic standards and plans including the Fifth National Mental Health Plan, Connecting Care to Recovery 2016 – 2021: A plan for Queensland's State funded mental health, alcohol and other drug services and the National Standards for Mental Health Services 2010.
- Identification and trialling of alternate and innovative service delivery models for allied health workforce, including co-located models of service and professional governance, which supports clinicians to focus on delivering therapeutic interventions and optimise access to services.
- Identification and trialling of potential key performance indicators for evidence based therapeutic clinical interventions within adult community mental health aligning with the needs of the population and guided by a national framework for recovery oriented mental health services: Guide for practitioners and providers (2013).
- Adaption of existing delegation training resources to facilitate their application to mental health allied health services.

Background and overview

Background

Allied health professionals bring a wealth of contemporary, diverse, specialist skills that contribute an essential role to quality recovery-focused service delivery within mental health services in QH. With a changing landscape in mental health service delivery the allied health workforce need to continue to look to new and innovative means of optimising these skills and expertise. This needs to include a focus on enhancing workforce scope of practice and how it can be best extended and expanded to continue to contribute to evidenced mental health service delivery outcomes (Ministerial Taskforce on health practitioner expanded scope of practice, 2014; Scope it right, 2015).

At a professional level, working to full scope of practice can be defined as a workforce that is able to use their skills to their full potential in terms of what they do and their capability to do it (Ministerial Taskforce on health practitioner expanded scope of practice, 2014). Working to full scope of practice requires opportunities to develop and enhance skills and capacity to utilise knowledge and hone expertise in a way that is efficient, adaptive and collaborative, evidenced, and fundamentally holds the consumer, their carer and family at the centre (Davis, 2011). A lack of clarity regarding full scope of practice can result in; inconsistent practice, underutilisation of skills, poor consumer outcomes, role creep, and role overload, and workforce retention issues (WHO, 2008).

Workforce challenges

There is a pressing need to develop opportunities to explore and map allied health scope of practice within mental health services due to a dearth of international literature on full or extended scope of practice in community mental health. Building evidence of scope of practice in the mental health sector will enable a more efficient and evidenced approach to service delivery (Dubois & Singh, 2009). Allowing mental health allied health to develop initiatives and strategies that will optimise consumer outcomes.

It is a period of significant transformation in the provision of current mental health services and the workforce that delivers them (Connecting care to recovery 2016-2021; Fraher, Harden & Kimball, 2011).

Within this environment allied health need to define how their scope of practice aligns with and supports these changes. These changes include: more funding and support for an increase in collaboration with community sector organisations in mental health service provision (Connecting care to recovery 2016-2021); the capacity building of primary care practitioners to be able to address the needs of consumers with mild to moderate mental health problems; and a growth in additional areas of workforce for example the growing consumer, carer and peer workforce across all areas of service delivery. It is important that allied health consider their scope of practice in order to align and integrate with these changes (Scope it right, 2014; Getting it right, 2014).

Challenges include:

- Limited state-wide mapping of allied health mental health professionals' skills/tasks to date, with the last review being the QH Community mental health services in Queensland time and motion study (2015).
- A need to understand the full scope of practice of allied health professionals in mental health in order to more effectively and efficiently utilise the workforce in mental health service provision. This would include building opportunities to better utilise other areas of workforce more effectively in order for allied health to work to their full scope.
- Enhancing the evidence-base of allied health therapeutic interventions and fostering an environment of best practice and enhancing the effectiveness of recovery focused service delivery.
- Developing clear descriptions of the full scope of practice for the mental health allied health professions in order to progress exploration of extended scope roles.
- Reviewing scope of practice in alignment with the principles of delivering recovery based patient centred care, building of collaborative teams, and ensuring quality and safety.

Context

Overview of Adult Community Mental Health Teams

For the purpose of this project two of the QH adult community mental health models of service were selected, the CCT and MIRT. These models have in common the tradition of case management, which involves the single point of contact coordination of care by a mental health professional and is inclusive of tasks that focus on assessment, planning, referral and monitoring (Rapp & Goscha, 2004). The Acute Care Team (ACT) and MH Call were not included in this project due to the time and resource constraints.

The MIRT offers intensive case management support to mental health consumers, providing rehabilitation and recovery interventions (Suggett, Lloyd, Meehan & King, 2013). MIRT specifically targets consumers with complex to chronic mental health and social issues which may result in frequent or lengthy inpatient unit admissions, poor engagement with services, and difficulty with general functioning and community living. The MIRT multidisciplinary professional team offer a combination of clinical and non-clinical support to consumers.

CCTs deliver a case management care coordination model of service for adults over the age of 18 and are seen as the mainstay of community mental health services across Australia (Suggett, Lloyd, Meehan & King, 2012). CCT offer a case management service to consumers with complex mental health needs who would benefit from a multidisciplinary approach due to the intensive or complex nature of the care required. The majority of CCT consumers experience moderate to severe impairment in functioning due to mental illness (Rapp & Goscha, 2004).

Project overview

Purpose

The purpose of the project is to contribute evidence for future mental health allied health workforce design that supports allied health to work to their full potential. At a time where there is significant mental health service delivery reforms it is important to highlight and map the potential, diversity and expertise of mental health allied health professions and their contributions to effective multidisciplinary teams.

Aims

The aim of the project was to describe the scope of clinical practice of the occupational therapy, psychology and social work professions in mental health community adult services.

Scope

Although adult community mental health teams are multi-professional, only the professions of occupational therapy, psychology, and social work were within the project scope. These professions are the primary allied health professions in the mental health workforce in Queensland.

Objectives

To identify tasks undertaken by the mental health allied health adult community workforce including:

- Profession specific tasks for occupational therapy, psychology, and social work, including shared practice tasks that are in the scope of more than one profession.
- Skill sharing tasks that are currently in scope of one profession, but may be appropriate and safe to skill share, assuming training, supervision and clinical governance processes are in place.
- Tasks that may be delegated or provided by other workers or other service providers, assuming training, support/supervision and clinical governance processes are in place.

Deliverables

There are two main deliverables for the project:

1. A comprehensive list of clinical tasks and functions related to the current scope of practice for professions of occupational therapy, psychology, and social work within the five sample adult community mental health service teams. This aggregated list comprises:
    - 76 tasks covering 5 clinical functions and 6 clinical areas
    - Information on the occupational therapy, psychology, and social work workforce undertaking each task in project sites and an approximated aggregated frequency of performance by the team
    - Decisions relating to clinical tasks and functions which could safely and appropriately be delegated to clinical support workers such as allied health assistants or skill shared between health professions (assuming appropriate training and assessment, clinical governance and service support processes are in place)
    - Decisions relating to current or potentially safe and appropriate allocation of non-clinical (administration, operational) tasks to non-clinical support workers (internal or external agency) if appropriate training, process/ procedures and service supports are in place.

    The aggregated task list and summary findings for the professions of occupational therapy, psychology, and social work are presented in the appendices as outlined below:
    - Appendix 6 Aggregated Clinical Task List Findings (Project and Review Sites)
    - Appendix 7 Task Analysis Findings
    - Appendix 8 Occupational Therapy Findings
    - Appendix 9 Psychology Findings
    - Appendix 10 Social Work Findings
    - Appendix 11 Allied Health Expert Review Findings
2. Final project report with recommendations

Terms and resources

Timeframes for completion of this project was 30 weeks from April to November, 2016.

A project manager was engaged through an internal Queensland Health EOI process, at 0.6 full time employee (FTE) from March to November 2016. The Project Manager was accountable to the Chief Allied Health Officer for delivery of the project as outlined in the project milestones. The Project Manager was provided with work space within their current HHS while working on the project. The Project Manager was funded by the Allied Health Professions Office of Queensland.

Four (4) site coordinators were provided by participating project sites at approx. 0.2 FTE funded for 3 months and worked closely with the Project Manager. Part funding (i.e. $10,000) was provided to participating sites (with half paid in advance and half on completion of the project deliverables) from AHPOQ. The main costs of the project site analysis were the responsibility of the participating site.

In-kind support from the HHSs was provided to allow all members of the team to attend awareness workshops and to allow allied health staff time to prepare for and attend task analysis workshops. Local management provided management and leadership of the project in the HHS.

Governance and stakeholder engagement

The project was sponsored by the Chief Allied Health Officer. The Site Coordinators and Project Manager operationally reported to management within their HHS.

The Project Manager and Site Coordinators were supported by a small Project Working Group which had regular communication/meetings particularly during the start of the project. A Project Steering Group was also formed and the Terms of Reference for the group are provided in Appendix 2.

A reference group was formed to provide guidance, support and promote the implementation of the project. The membership of the reference group included mental health allied health leadership representatives from each HHS (i.e. members from the current Allied Health Mental Health Steering Committee (AHMHSC)). The Reference Group Terms of Reference are provided in Appendix 3.

Key concepts

The following are descriptors of the key concepts referred to in the project.

Remain with current professions

The task will be retained and limited to delivery by the profession or professions currently providing the task.

Skill sharing

Skill share refers to two or more allied health professionals sharing knowledge, skills and responsibilities across professional boundaries in assessment, diagnosis, planning and/or implementation. The requirement for a particular role to practise in a trans-professional way must be embedded in the role description. There are significant clinical governance and supervision considerations associated with these roles.

Skill-sharing cannot be used as substitution of a profession or workforce group in the team as access to the expertise of the skill-sharing profession is required to support implementation of the model and for management of complex clients which fall outside of the models' limits.

Shared practice

The task is consistent with the existing scope of practice of practitioners in more than one profession. This may indicate the task is based on knowledge and skills that are common to the pre-entry training standards of each profession, or that it is consistent with the accepted scope of practice of the professions developed through post-entry work-based training and clinical experience.

Delegate

Delegation is defined as the process by which an allied health professional delegates activities to a clinical support worker who has appropriate education, knowledge and skills to undertake the activity safely. It has also been identified that delegation involves the conferring of authority on the clinical support worker to perform activities that would otherwise be performed by an allied health professional, whilst the allied health professional retains the responsibility for the task.

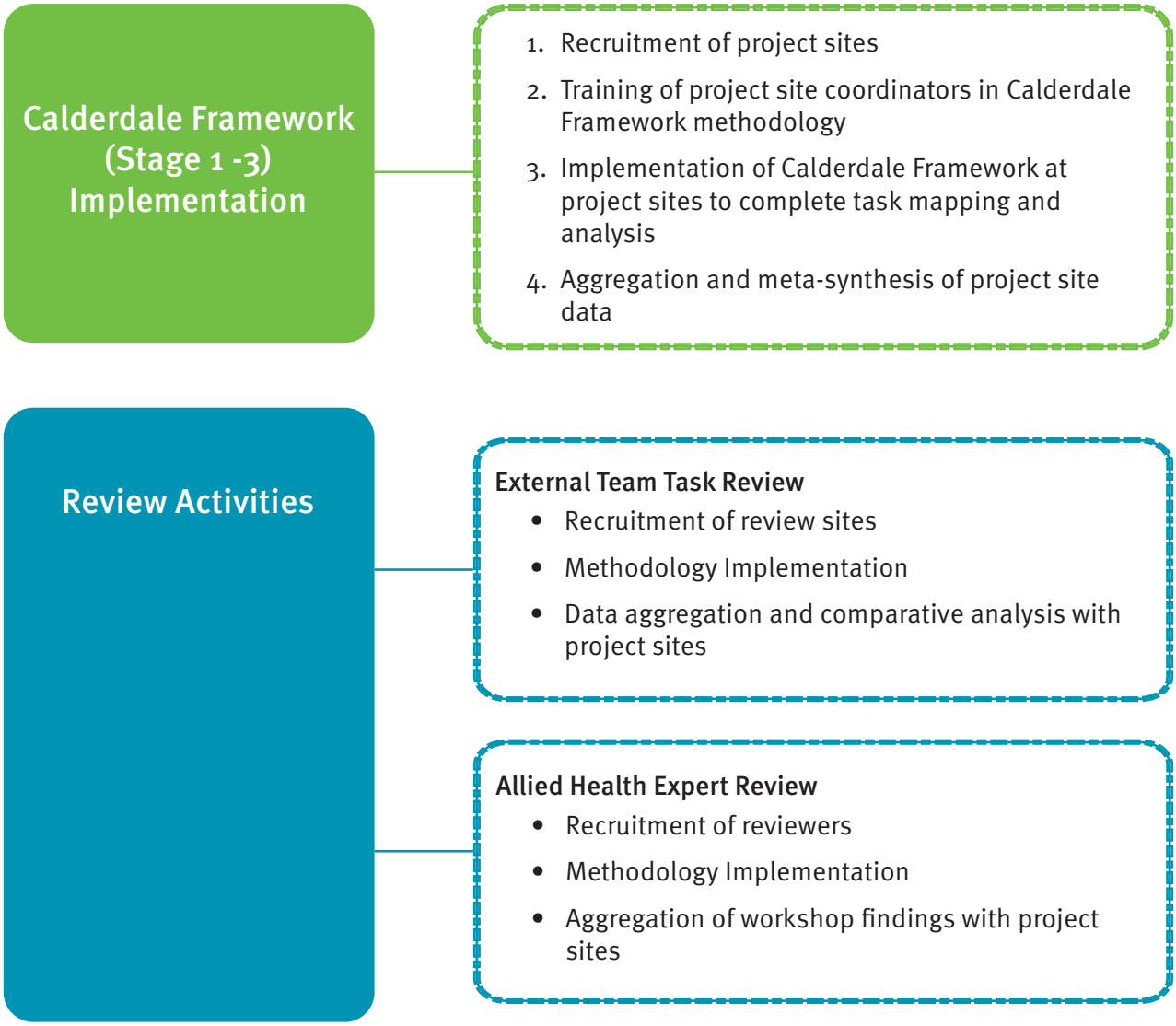
Assign

Assigning an activity is defined as the process by which an allied health professional assigns a task to a non-clinical workforce (e.g. administration, support worker) who has been employed by an organisation (internal or external) to undertake the activity. The assigned activity must have no clinical knowledge requirement and have no negligible clinical risk associated with it. There must be a clear feedback loop established to provide non-clinical feedback to the allied health professionals as appropriate. The organisation will have determined that the task is able to be assigned, that the task is defined and accepted. Assign differs from and is not delegation.

Project strategy and activities

The project activities are outlined in Figure 1 below.

Figure 1: State-wide Mental Health Allied Health Scope of Practice Project Activities



Calderdale Framework Implementation

Recruitment of project sites

Adult community mental health teams from four (4) hospital and health services across Queensland were selected through an Expression of Interest process to implement the first three stages of the Calderdale Framework at their locations. Participating teams were:

- MIRT – Cairns & Hinterland Hospital & Health Service
- CCT 1 and 2 – Darling Downs Hospital & Health Service
- CCT – Gold Coast Hospital & Health Service
- CCT – West Moreton Hospital & Health Service

Training in calderdale framework methodology

The Calderdale Framework provided a structured process for teams to map all clinical tasks undertaken by the team and to analyse each task using a risk based structured decision tool for potential to skill share or delegate the task. Information on the Calderdale Framework is presented in Appendix 1.

Project Site Coordinators (PSC) and an additional Calderdale Framework Facilitators were appointed at each of the four project sites and completed the following Calderdale Framework Facilitator training requirements:

- Foundation Workshop
- Day 1 –3 of Facilitator Workshop
- Day 4 – 5 of Facilitator Workshop

The PSC was supported to implement the first three stages of the Calderdale Framework methodology at their respective sites as part of the project.

Implementation of calderdale framework

Implementation of the Framework at each site involved:

- Awareness Raising - Stage 1
  - Delivery of the one day Calderdale Framework Foundation training program to team members at local sites
- Service Analysis – Stage 2
  - Mapping of clinical tasks currently undertaken by the team and compilation of descriptive information including: professions involved in delivering the task and approximations of task frequency
- Task Analysis – Stage 3
  - Use of a risk based structured decision tool to examine the potential for clinical tasks to be skill shared with other allied health professions or delegated to clinical support workers

Data aggregation and meta synthesis

Descriptive task lists for each site were submitted to the Project Manager for aggregation and compilation into a preliminary task list representative of the clinical practices of occupational therapy, psychology, and social work within adult community mental health services across project sites.

Further information on the methodology for project sites is provided in Appendix 4.

Review activities

There were two separate validation activities in relation to the preliminary aggregated task list that ran concurrently: External Team Task Review and the Allied Health Expert Review Group.

External Team Task Review Activity

Purpose

The purpose of this review is to provide information on the validity of the data collected from project sites and additional information on clinical tasks undertaken by practitioners in community adult mental health teams.

Recruitment

Occupational therapy, psychology, and social work team members from an additional six adult community mental health teams in hospital and health services external to the project sites were selected for the external team task review. Teams with a minimum representation of two staff from the participating teams were:

- Redcliffe Adult Mental Health Team – Metro North HHS
- Princess Alexandra Mobile Intensive Rehabilitation Team & Logan Mood ACU – Metro South HHS
- Mobile Intensive Rehabilitation Team – Sunshine Coast HHS
- Rockhampton Adult Community Case Management Team and Gladstone Adult Mental Health Team – Central Queensland HHS

Method

Implementation of the review activity at each of the external sites involved:

- Participation in an online orientation session to familiarise team members with the purpose, methodology and data collection tools
- Collection of data on type and frequency of clinical tasks performed by individual clinicians over a five day period using a template based on the preliminary aggregated task list, as well as any additional tasks not noted on the template

Further information on the methodology for the External Team Task Review is provided in Appendix 5.

Data aggregation and comparative analysis with project sites

Individual participants at each site submitted their collated data to the Project Manager for aggregation and analysis as an overall team as well as the professions of occupational therapy, psychology and social work.

Comparative analysis of data from the project sites was also undertaken. Findings from the review activity contributed to the development of the final project aggregated clinical task list, as well as informing the findings and recommendations for the final report.

Allied Health Expert Review

Purpose

The purpose of the review is to provide the State-wide Mental Health Allied Health Scope of Practice Project with expert advice on the scope of practice for allied health professionals delivering adult community mental health services.

The Group will review the aggregated task list generated from the local teams' implementation

Recruitment

Two (2) senior QH clinical staff and 2 tertiary education sector representatives from each of the professions of occupational therapy, psychology, and social work were identified and invited to participate in the review group.

Method

The implementation of the Allied Health Expert Review methodology involved:

- Participation in an online orientation session to familiarise group members with the purpose, methodology and documentation
- Participation in one of two workshops to provide specific advice on:
  - » data within the preliminary aggregated clinical task list with regard to clinical tasks currently undertaken by allied health professionals delivering adult community mental health services, and
  - » rating the potential value for clients and health services of implementing the task delegation / assignment / skill share decisions provided by project sites.

Further information regarding the Allied Health Expert Review is provided in Appendix 12.

Aggregation of Findings with Project Sites

Workshop findings were collated and analysed by the Project Manager and contributed to the development of the final project aggregated clinical task list as well as informing the findings and recommendations for the final project report.

Project findings

Results

- A total of 76 clinical tasks were identified by the 5 project sites across a range of functions including assessment, intervention, care coordination and review. Interventions were the largest percentage of functional tasks (42 per cent), followed by assessment (37 per cent) and care co-ordination (16 per cent). Sixty one percent of assessment tasks (17 out of 28) and 75 per cent of care coordination (9 out of 12) tasks were performed at a high frequency across project sites. Eighteen percent (6 out of 32) of intervention tasks were performed at a similar frequency.
- In relation to the clinical areas covered in the task list, Psychological & Behavioural had the largest proportion of tasks (61 per cent), followed by Activities of Daily Living (ADL) & Function (20 per cent) and Social – Psycho Social (12 per cent) respectively. Other clinical tasks areas included Cognition, Memory & Perception, Medications and Vital Signs, Observations and Clinical Measurements. The aggregated clinical task list is provided in Attachment 1.
- Although not within the scope of task analysis in this project, project sites identified a significant number of non-clinical tasks that were being performed by the three professions. These fall under three broad categories and relate to professional, administrative or operational aspects of service delivery to consumers within the adult community mental health context. A list of commonly identified non clinical tasks from project sites is provided in Appendix 6.
- There was some evidence of extended scope of practice with project sites reporting the performance of clinical tasks relating to medication monitoring and compliance and metabolic monitoring.
- No tasks included in project site data were identified as being delegated to a clinical support worker or assigned to a non-clinical support worker prior to undertaking the task analysis phase.
- Task analysis decisions from the project sites reported that 64 per cent of clinical tasks should remain with the current profession(s). The remaining 36 per cent of tasks were identified as potentially appropriate for delegation to a clinical support worker. Tasks identified for delegation related to: screening assessment; ADL functional training, social skills training; relaxation and mindfulness therapies as well as psych- education on sleep hygiene and basic nutrition and exercise.
- No clinical tasks were identified as appropriate for skill share across the project sites. Some sites did identify the potential of skill sharing of some tasks (such as metabolic monitoring) from nursing but this was not within the project scope.

Review activities

- There were a number of activity areas identified by the review sites and the expert group that fell within the expected scope of practice for the three professions but were absent from the aggregated task list. Specific examples of this are the absence of tasks relating to cognitive interventions (such as cognitive remediation) and the assessment of functioning related to vocational / leisure domains.
- Multi-professional delivery of tasks was common with 83 per cent of tasks at project sites and 90 per cent of tasks at review sites being delivered by more than one allied health profession. Of the 76 tasks listed, only one: CP002 Cognition Screening Assessment using standardised tools: Montreal Cognitive Assessment (MOCA), ADLS, Addenbrookes Cognitive Examination Revised (ACER), Differential Ability Scales (DAS) & Mini Mental State Examination (MMSE), was not performed at any of the review sites during the review activity.
- There was also consistency in relation to the proportion of the total number of tasks being performed at both project and review sites by occupational therapy (93 per cent and 91 per cent of tasks), psychology (84 per cent and 80 per cent of tasks) and social work (86 per cent and 91 per cent of tasks).

Additionally expert reviewers identified:

- value in the delegation of a number of tasks including:
  - a range of screening assessments (e.g. physical functioning, cognition);
  - housing and accommodation support;
  - subjective history taking;
  - facilitating client access and engagement with health and social support services; and
  - functional training in personal, domestic and instrumental ADL's
- Some potential risks associated with the proposed delegation of some assessment measures and therapeutic interventions. These were based on concerns about the appropriate and consistent use of assessment tools and therapeutic interventions in line with current evidence based practice guidelines, especially in relation to the high level of multi-profession delivery identified within the project.

Key findings

Analysis of the project data revealed five key findings.

Profession scope of practice is influenced by case management service delivery model and localised context

The difficulties of the adult community mental health workforce to conceptualise and provide concrete descriptions of the range and scope of tasks performed were demonstrated. Although the aggregated task list was reflective of the functional and clinical area elements expected within the scope of the occupational therapy, psychology, and social work professions, it is not exhaustive with external and expert review findings identifying some areas of deficit.

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The development of key performance indicators that align with current evidence based practice guidance may also support increased provision of therapeutic interventions.

Multi-professional delivery of clinical tasks is common practice

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It is difficult to definitively identify the relative mix of skill sharing and shared practice tasks. A proportion of tasks either aligned with generic capabilities / practice standards for the mental health workforce (such as mental health capacity, mental state and risk) or as key functions within the case manager role that exists within community mental health practice (coordinating treatment and referrals). These are likely to be shared practice tasks.

Remaining tasks identified as being multi-professional in delivery could be attributed to the sharing of these clinical skills at project sites between professions. Some of the tasks within this grouping sat outside the accepted or traditional scope of practice of the professions involved in their delivery. It is however beyond the scope of this project to ascertain whether the skill sharing of these tasks at the local level is the result of a formal teaching and competency assessment process between the professions involved or other factors such as local workforce or workload issues, service needs or service delivery models.

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Project performance and evaluation

Project management

Project plans at the state-wide and local project site levels were used to ensure that key project milestones and deliverables were met as well as mitigate potential risks. GANNT charts were used at project sites to monitor progress and these were used to inform and update the larger project GANNT.

Regular meetings of the project Steering and Reference Groups provided oversight and advice to the Project Manager. Regular meetings between the Project Manager and the local project site coordinators individually and as a group also allowed for the early identification of potential problems and the development of solutions.

Project evaluation

Process evaluation

- Project activities completed within allocated budget and within approved timeframes. The majority of project activities including site deliverables have been completed within the approved timeframes. There have been some delays in relation to the completion and submission of Completion Reports from some project sites as well as pre and post project evaluation data.
- Project Completion Report. The project completion report will be submitted to the project steering committee for review and recommendation to the project sponsor.

Impact evaluation

Pre- and post-project evaluation data

The survey was developed from change readiness tools used for previous Calderdale Framework projects in Queensland. It was distributed to all participating team members in project sites by the project site coordinators and was to be completed at the start of the Service Analysis stage and then again after the Task Analysis stage had been completed.

There were several issues with the impact data. Firstly, only one site completed the pre evaluation making it impossible to compare pre and post evaluation results. Completion of the surveys by team members was also voluntary, resulting in a response rate of 40 per cent (12 out of an approximate 30 participants) for the post evaluation.

Post evaluation data was also only provided from three of the five project teams.

Due to the response rate, considerable selection bias is likely and the data must be interpreted with caution. The following is summary of the general themes from the survey data:

Service provision

- Respondents identified that their teams provided a service that was of benefit to consumers and generally effective in communication, coordinating consumer care and providing timely access to services.

Team workforce

- Respondents agreed that that there was clear understanding of roles and functions of the various team members.
- There was greater variation in responses around the difficulties new staff may have in adjusting to the team's model of care and meeting the clinical requirements of their role as well as the ability of team members to work to their full scope of practice.

Project participation and value

- Views around being involved in the project were generally positive and participants felt that they had the necessary skills, time and capacity to participate
- The identification of greater opportunities for skill sharing and task delegation was valued
- There was less certainty around participant understanding of the project rationale, the extent to which it was being driven within the team as well as the adequacy of available resources to support project implementation. Management were seen to be supportive of the project.
- Respondents also varied in their views as to how the project would benefit the team, particularly in regard to staff recruitment and retention as well as the broader service context and consumers using the service
- There was general support for the use of the Calderdale Framework within the project but less certainty around whether it would enhance project outcomes.

Limitations

A number of limitations were identified relating to the collection, interpretation and analysis of data from the project.

Data collection

- The variation in understanding, interpretation and implementation of the Calderdale Framework at individual project sites impacted on the representation of task information and decisions in data collection, despite the use of a tightly prescribed common methodology and standardised data collection tool. Examples include task analysis decisions around skill sharing, delegation and assignment of tasks (for example: skills sharing tasks with clinical support workers and delegating clinical tasks to non-clinical staff).
- The recording of information on the standardised data collection tool was subject to how clinical tasks were interpreted by sites (for example the grouping together of psychotherapy and psycho-education interventions rather than as separated tasks). This resulted in some tasks having insufficient descriptions and other related information such as frequency performed and by which professions.
- System compatibility issues created some minor issues between sites and the project manager using different versions of excel software. This did result in some reports of missing and / or corrupted data.
- Differences in the role and purpose of teams at individual sites (for example MIRTs versus CCTs) and the associated model of service delivery are expected to have impacted on the range of clinical tasks reported as being performed.
- Different methods of capturing task data between project and review sites. Individual clinicians at review sites recorded an actual performed task frequency over a five day period against a pre-determined task list. In contrast, project sites had to generate their own clinical task list based on their own practice and report an aggregated team task frequency. This made some data comparisons difficult or not possible, such as comparing the frequency of profession based task performance between review and project sites.
- Differences between review and project sites in the interpretation of the components involved in performing a task.

  As project sites generated the task list, it is expected that they would have a clearer understanding of the task scope, compared to review sites that were provided with the task description only.

Data analysis

- The aggregation and analysis of the data from the project sites was interpreted by the State-wide Project Manager. Some level of bias and error in integrating this information into the aggregated task list is likely. It should be noted that the project manager who undertook the analysis does not have a clinical background in mental health or allied health and was not familiar with nor received training in the Calderdale Framework methodology and data collection tools. Strategies used to address this potential for bias and error included follow up communication with project sites to clarify information provided and advise from members of the project Steering Committee in relation to mental health allied health clinical practice and analysis of the data produced from the Calderdale Framework implementation.
- The need to recruit a new project manager just prior to the data aggregation and analysis stage in addition to the project timeframes for completion of review activities and other resource constraints did not allow for data analysis to be undertaken by more than one individual.

Lessons learned

Key learnings from the project are:

- Local capacity to implement the project would be enhanced if all identified project resources were available and utilised including:
  - more detailed information provided at the point of recruitment and induction of site coordinators, particularly in regard to:
    - » commitment to project duration (workload, contract arrangements etc.)
    - » Appropriate timeframes for local staff to complete components such as service and task analysis stages (issues with taking staff offline from clinical service demands).
    - » wider project methods, including the Calderdale Framework and key concepts (skill share, delegation and assign).

- State-wide capacity to implement and complete the project would be enhanced if the project manager is:
  - appointed prior to the planning and implementation of the project
  - trained in the project methodology (Calderdale Framework) and had experience in the relevant clinical context (adult community mental health) to act as a support for local site coordinators
  - committed to the project duration.

Project closure activities

The following activities will be undertaken to close the project.

Project site deliverables

- Sites and Project Leads will be supported to ensure submission and endorsement of deliverables from project sites, including Site Completion Reports.

Finance management

- Any outstanding arrangements for payment of project sites invoices will be submitted to the Project Sponsor, after endorsement of deliverables.

Records management

- All files and documents associated with the project will be provided to the Project Sponsor in electronic format.

Provision of final project report

- The final project report will be submitted to the Project Sponsor for endorsement.

Post project communication strategy

- A communication and engagement strategy will be developed to support the dissemination of the final project report, endorsed by the Project Sponsor.

Recommendations

The recommendations for future actions are linked to the key project findings and include:

- Review of the model of service delivery within adult community mental health services in line with the current national and state based mental health strategic standards and plans including the Fifth National Mental Health Plan, Connecting Care to Recovery 2016 – 2021: A plan for Queensland's State funded mental health, alcohol and other drug services, the National Standards for Mental Health Services (2010).
- Identification and trialling of alternate and innovative service delivery models for allied health workforce, including co-located models of service and professional governance, which supports clinicians to focus on delivering therapeutic interventions and optimise access to services.
- Identification and trialling of potential key performance indicators for evidence based therapeutic clinical interventions within adult community mental health aligning with the needs of the population and guided by A national framework for recovery oriented mental health services: Guide for practitioners and provider (2013.)
- Adaption of existing delegation training resources to facilitate their application to mental health allied health services.

References

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World Health Organisation. (2008). Task shifting: rational redistribution of tasks among health workforce teams: Global recommendations and guidelines. Geneva, Switzerland: World Health Organization.

Appendices

Appendix 1: Calderdale Framework

The Calderdale Framework was developed by two physiotherapists, Rachael Smith and Jayne Duffy, from the Calderdale and Hudderfield NHS Foundation Trust (UK). Smith and Duffy own the rights to the Calderdale Framework (Effective Workforce Program) and trade as a limited company called Effective Workforce Solutions. The Calderdale Framework (CF) has been used and evaluated in many allied health services in the United Kingdom for more than a decade. The Calderdale Framework was purchased by the Allied Health Professions' Office of Queensland in 2011 and has been rolled out in more than a dozen projects in the Queensland Public Health System since that time, including several in rural or remote allied health services. Outcomes from the UK and Queensland projects have indicated the following benefits to teams using the CF to structure and guide their model of care re-design process:

- Improved workforce planning capacity through definition of clinical tasks undertaken by the team
- Reduced duplication of tasks and increased timeliness of intervention
- Risk management, especially where informal skill sharing and delegation exists due to necessity and have not been adequately supported by training and competency assessment or clinical governance processes
- Investment in staff competency, professional development and growth
- Positive impacts on patient experience with the service

The Calderdale Framework is a 7-step process used to improve the way a health team works. It aims to provide a clear and systematic method of reviewing team skill mix, developing new roles and new ways of working and linking these workforce changes to service redesign to ensure safe and effective patient-centred care. It is a comprehensive clinician-lead process and team driven, with a Calderdale Framework trained Facilitator providing support with each step. The two main uses of the CF are to scope, design, implement, evaluate and monitor:

- a workforce and delegation model for professions
- a workforce model for skill sharing across professional disciplines

The State-wide Mental Health Allied Health Scope of Practice Project will involve the implementation of the first 3 stages of the Calderdale Framework only as part of the project with further development being the responsibility of the individual participating project sites. The team will have the training and resources to implement the full Calderdale Framework process if they wish to proceed further. As a guide the major activities by stage will be:

- training of the Project Site Coordinators
- a half-day training program provided by Project Site Coordinators to the site teams implementing the CF.
- **Stage 1: Awareness Raising**
  - meetings with key site stakeholders
- **Stage 2: Service Analysis**
  - Service analysis meeting/s as a team (4 hours)
  - Individual practitioners map current clinical tasks undertaken as part of normal work and collect time in motion information related to each task (information collected daily as part of practice)
- **Stage 3: Task Analysis**
  - Task analysis meeting/s as a whole team and as smaller groups (i.e. 2-3 practitioners) (one to several days in total duration – greatly depends on scope, for experienced facilitators this would take approximately 10 hours).
  - Individual practitioners review and revise tasks e.g. changing task descriptions, clarifying information in task.

Components that sit outside the scope of the State-wide Mental Health Allied Health Scope of Practice Project (and therefore are implemented at the discretion of the Project Site)

- **Stage 4: Competency development (time investment greatly depends on number and type of competencies)**

- **Stage 5: Supporting systems**
    - Identifying, developing and implementing changes to process within the team to support the new workforce model including changes to new role descriptions, orientation and induction processes, implementing a delegation and skill share framework, procedures and protocols to support the new model of care.
- **Stage 6: Training (time investment depends on extent of training required and staff capacity factors, both those being trained and those providing the training)**
- **Stage 7: Evaluation of the change to the model of care**

Further Information

- Effective Workforce Solutions: http://effectiveworkforcesolutions.com/
- Kaltner M, Wilson J, Scott A (2012). The Calderdale Framework: Shared Competencies and Delegation Practice. Health Workforce Australia Workforce Innovation Database. At: http://www.workforce.org.au/media/232418/kaltner,%20wilson%20&%20scott%20wic%20v2.pdf.
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Appendix 2: Project Steering Group terms of reference

Purpose

The purpose of the State-wide Mental Health Allied Health Scope of Practice Project Steering Group is to provide oversight, strategic advice and support for the development, direction and implementation of the project.

Responsibilities

Members agree to fulfil the following responsibilities:

- Contribute to the development and implementation of the project at both the local and state-wide level
- Provide advice and support to the State-wide Project Manager to ensure that that key project milestones and deliverables are met.

Organisational structure

Sponsor

The Allied Health Professions' Office of Queensland is the sponsor of the project.

Chairperson

Chief Allied Health Officer, Allied Health Professions' Office of Queensland (AHPOQ)

Secretariat

Secretariat to the group will be provided by the Project Manager, State-wide Mental Health Allied Health Scope of Practice Project.

Membership

Chief Allied Health Officer, AHPOQ
State-wide Professional Practice Leader – Social Work
Allied Health Professional Practice Leader AHPOQ
Principal Workforce Officer AHPOQ (PPO)
State-wide Project Manager

Other participants

Where agreed to by the Chair, other persons may participate as a guest in the Group's proceedings/ activities. However, such persons do not assume membership and cannot participate in any decision-making processes of the Group.

Quorum

A quorum will require the Chair and 50 percent of membership. In the absence of a quorum, the meeting may continue at the Chair's discretion with any items requiring decision to be differed and circulated following the meeting to Members as an Out-of-Session item.

Meeting frequency

The State-wide Mental Health Allied Health Scope of Practice Project Steering Group will meet fortnightly. Extraordinary meetings may be scheduled as and when required. The meetings will be of one hour duration.

Out-of-session items

Any urgent matters unable to be deferred to next meeting or any follow up decisions may be managed as an Out-of-Session item. The Out-of-Session item will be sent to the members via email with a requested response date.

For a resolution to be approved, the majority of members must indicate their endorsement by the response date. It is agreed that if members do not respond, it will be assumed that they are supportive and/or agree with the matter.

If approved, the resolution will be entered into the minutes of the next meeting. If not endorsed by a majority of members, the item will be deferred until the next meeting.

Conduct

Discussions will be respectful and value the contribution of all members. The conduct of members will be consistent with the Queensland Government Code of Conduct at all times.

Notwithstanding the information sharing and consultation function of the State-wide Mental Health Allied Health Scope of Practice Project Steering Group matters discussed will be treated as confidential by members, unless indicated otherwise by the Chair.

Business rules

Agenda and records

Members wishing to place items on the agenda must notify the secretariat at least ten working days prior to the scheduled meeting. The agenda and relevant papers will be approved by the Chair prior to distribution.

The agenda and relevant papers will be sent out to all members no later than 1 week prior to scheduled meetings.

Late agenda items will be tabled at the discretion of the Chair.

Electronic copies of documentation distributed to and received from members will be kept and maintained by the Secretariat.

Attendance

Teleconference or videoconference facilities will be available for any member who cannot attend a meeting in person.

Terms of reference

The terms of reference for State-wide Mental Health Allied Health Scope of Practice Project Steering Group will be reviewed every 12 months. The next review date will be June 2017

Appendix 3: Project Reference Group terms of teference

Purpose

The purpose of the State-wide Mental Health Allied Health Scope of Practice Project Reference Group is to:

- Provide guidance and support for the implementation of the initiative
- Promote the initiative within the Hospital and Health Services (HHS)
- Provide a forum for reporting on the progress of the implementation of the project activities, identification of risks and achievement of project milestones in the Project Site HHSs.

Responsibilities

Members agree to fulfil the following responsibilities:

- Contribute to the development of the mapping the scope of practice for Allied Health Practitioners in Mental Health Services – Community Adult.
- Provide advice and expert opinion about issues relevant to allied health professions in mental health services.

Organisational structure

Chairperson

Chief Allied Health Officer, Allied Health Professions' Office of Queensland (AHPOQ)

Secretariat

Secretariat to the group will be provided by the Project Manager, State-wide Mental Health Allied Health Scope of Practice Project.

Membership

Chief Allied Health Officer, AHPOQ
State-wide Professional Practice Leader – Social Work
Allied Health Professional Practice Leader AHPOQ
Principal Workforce Officer AHPOQ (PPO)
Director of Allied Health, MSAMHS
Director of Allied Health, Darling Downs HHS
Director of Allied Health MH& ATODS, Cairns HHS
State-wide Professional Practice Leader AH CYMHS
Director of Psychology, Gold Coast HHS
AH Professional Leader, Senior CYMHS Clinician, Division of Mental Health and AODS, Mackay HHS
Director Allied Health, West Moreton HHS
Community Programs & Allied Health Director, Central Queensland
Director Allied Health Mental Health, Metro North HHS
Clinical Education Program Manager- Psychology, State-wide Psychology Clinical Education
Director Allied Health Mental Health, Townsville HHS
A/Director, Clinical Governance, Mental Health Branch
Program Manager, QLD Centre for Mental Health Learning

Proxies

A member may provide a suitably briefed proxy if they are unable to attend. The member will notify the Chair via email prior to the proxy's attendance.

Other participants

Where agreed to by the Chair, other persons may participate as a guest in the Group's proceedings/ activities. However, such persons do not assume membership and cannot participate in any decision-making processes of the Group.

Quorum

A quorum will require the Chair and 50 percent of membership. In the absence of a quorum, the meeting may continue at the Chair's discretion with any items requiring decision to be differed and circulated following the meeting to Members as an Out-of-Session item.

Meeting frequency

The State-wide Mental Health Allied Health Scope of Practice Project Reference Group will meet monthly. Extraordinary meetings may be scheduled as and when required. The meetings will be of one (1) hour duration.

Out-of-session items

Any urgent matters unable to be deferred to next meeting or any follow up decisions may be managed as an Out-of-Session item. The Out-of-Session item will be sent to the members via email with a requested response date.

For a resolution to be approved, the majority of members must indicate their endorsement by the response date. It is agreed that if members do not respond, it will be assumed that they are supportive and/or agree with the matter.

If approved, the resolution will be entered into the minutes of the next meeting. If not endorsed by a majority of members, the item will be deferred until the next meeting.

Conduct

Discussions will be respectful and value the contribution of all members. The conduct of members will be consistent with the Queensland Government Code of Conduct at all times.

Notwithstanding the information sharing and consultation function of the State-wide Mental Health Allied Health Scope of Practice Project Reference Group matters discussed will be treated as confidential by members, unless indicated otherwise by the Chair.

Business rules

Agenda and records

Members wishing to place items on the agenda must notify the secretariat at least ten working days prior to the scheduled meeting. The agenda and relevant papers will be approved by the Chair prior to distribution.

The agenda and relevant papers will be sent out to all members no later than 1 week prior to scheduled meetings.

Late agenda items will be tabled at the discretion of the Chair.

Electronic copies of documentation distributed to and received from members will be kept and maintained by the Secretariat.

Attendance

Teleconference or videoconference facilities will be available for any member who cannot attend a meeting in person.

Terms of reference

The terms of reference for State-wide Mental Health Allied Health Scope of Practice Project Reference Group will be reviewed every 12 months. The next review date will be June 2017.

Appendix 4: Project methodology

Project site methodology

Recruitment

Up to five project sites were sought, meeting the following criteria:

- Executive support from service
- Full multidisciplinary team representation
- Senior project leads at local level to act as site coordinators
- Capacity to commit to project timeframe
- Commitment to continue scope of practice work post the project completion

Data collection at project sites

Project sites completed and submitted an excel based data collection form to the Project Manager as the primary project deliverable. Data collected included:

- Team / service descriptive data including professions / workforce groups represented in team, FTE, service locations
- Master Task List including:
  - Clinical task descriptive data including:
    - » Broad function (assessment, intervention, care coordination, administration, professional, operational) – pre loaded into data template (based on findings from Queensland health projects), but could also be amended or added to if required;
    - » Clinical area (ADL & Function, Cognition, Memory & Perception, Medications, Psychological & Behavioural, Social & Psycho-Social, Vital Signs, Observations & Clinical Measurements) – pre loaded into data template (based on findings from Queensland health projects), but could also be amended or added to if required
    - » Task title (defined by team)
    - » Task description (defined by team)
    - » Task frequency chosen from the following categories: daily; 2-3 times / week; weekly; fortnightly, monthly; 2-6 monthly; less than 6 monthly. This was the approximate frequency hat the task was performed by the team (all relevant members); and
    - » Professions currently undertaking the task and whether the task was currently delegated to a clinical support worker or assigned to a non-clinical support worker.
  - Tasks analysis data including:
    - » Decision of team to skill share, delegate, assign or keep the task with the current profession(s)
    - » If the decision was to skill share or delegate, which professions in the team would be most appropriate for the task to be shared with or delegated to considering:
      - The potential benefits and risks to clients
      - Efficiencies for the service
      - Efficiencies in terms of extent of training required to undertake the task, balanced against potential benefits / risks and service efficiencies listed above
    - » Existing training resources available to the team to support skill sharing or delegation if this was the decision of the team
  - Task analysis decision tables. These are part of the Calderdale Framework and examine, using a 10 point risk analysis process, the potential for skills sharing or delegation of the clinical task. The decision tables captured additional data including the rationale for a decision or the scope of the decision e.g. skill sharing only a component of the task.

Project sites also completed and submitted a list of up to three additional clinical tasks that they do not currently perform but have identified as high frequency needs and high impact on consumer recovery outcomes.

Aggregation and analysis of project site data

Aggregation of project site data was undertaken in two phases: task list aggregation and task decision aggregation and analysis.

Task list aggregation

Following completion of the service analysis stage of the Calderdale Framework, project sites submitted their draft master task list to the Project Manager. The service analysis stage produced a list of the clinical tasks undertaken by the team (including all data described above). Aggregation of project site data was undertaken by the Project Manager to produce a single task list. This involved aggregating task descriptive information into a single task list:

Reviewing all tasks supplied by projects and clustering them by clinical area

- Clustering like tasks together as indicated by task title or description. Some tasks were presented consistently across sites (e.g. risk assessment was presented as a standalone task with consistent task description in a number of sites. The remaining tasks were drawn from information presented in different ways by project sites. To develop tasks from disparate representations in project site data, the Project Manager used the following decision rules:
  - » Assessment and intervention activities were divided into separate tasks. This was based on advice from the Steering Group around previous work using the Calderdale Framework and experience that often assessment and intervention processes have different decisions regarding delegation or skill sharing.
- Project site data that presented a single clinical activity as multiple separate task were remained separated on the aggregated task list if:
  - » The different activities had a similar risk profile and / or underpinning knowledge and skills and therefore would be likely to produce the same decision regarding skill share or delegation – comprehensive assessment ADL & Function remained a single task that included a broad range of clinical activities
  - » Training for skill sharing or delegation , if relevant would logically include the different activities as a cohesive skill set
  - » Low task frequency indicated it was unlikely to be skill shared or delegated and remaining as a single task was efficient
- Project site data that presented multiple clinical activities as a single task were expanded into multiple tasks in the aggregated task list if:
  - » The risk or complexity of activities was different
  - » The underpinning knowledge and skills are significantly different
  - » A standardised testing process if relatively low risk / complexity could be drawn out from the broader task, as this was more likely to be amenable to delegation of skill sharing
- Task Frequency
  - » Task frequency was collected by all project sites for each task they identified. Project site data indicated the approximate frequency that the task was performed by the team. When the sites' task list data was aggregated, frequency was estimated by comparing site responses. Frequency was broadly categorised in the aggregated task list as follows:
    - » High Frequency Task occurs at least once a week
    - » Moderate frequency Task occurs less than weekly but more than monthly
    - » Low frequency Task occurs monthly or less frequently
  - If there was a discrepancy between task frequencies recorded between sites, the average frequency was determined as follows:
    - » An 'outlier" was discounted if multiple other sites had high consistency
    - » If the task was identified at a number of sites, the average was used.
  - For tasks that were expanded, the frequency was recorded as unclear regardless of whether the initial single task had a frequency recorded (for example – psychotherapies were listed as high frequency but the individual therapies listed were recorded as unclear)

Professions / workforce groups currently performing task in sites:

- Project site data indicated that team members currently responsible for undertaking the task. All professions / workforce groups listed in the site data were included in the aggregated task list except if comments in the data collection form indicated otherwise.
- By default, the professions listed were understood to provide the full scope of the task. Professions were recorded as providing a part of the task or inconsistently providing the task if:
  - » The task was identified at two or more sites with that profession in staffing establishment but was not contributed consistently to the profession,
  - » A comment in the data collection tool indicted the profession provided only limited scope of the task
  - » Multiple tasks in the site data had been combined into one in the aggregated ask list and there was a discrepancy between the professions listed for the component tasks in the project site data
- The draft aggregated task list was reformatted as a data collection form for use by other adult community mental health teams in the external review activities (refer below).

Task decision aggregation and analysis

- The task analysis stage of the Calderdale Framework produced decisions from the project sites regarding the appropriateness of each task for delegation, skill share or assignation to other team members. Tasks were listed as potentially able to be skill shared or delegated if one or more sites identified that to be the case.
- If data indicated that only a component of the task should be skill shared or delegated, either in the comments section of the data collection tool or in the construction of the task description – the profession that would take on the skill share task was listed as "skill share (relevant profession) – component on the aggregated list task.
- All delegated tasks were understood to be limited in scope to the components of the task that are consistent with a delegated practice model of care.

Checking process

- Project sites did not get the opportunity to review and provide feedback on the aggregated task list. This was due to a number of factors including delays in receipt of data from one site, clarifying data from the original site data collection sheets, consequent delays in completing the data aggregation and analysis as well as the project timeframes for completion of the review activities.

Appendix 5: External Team Task Review methodology

External site recruitment

Up to six project sites were sought, meeting the following criteria:

- Community adult mental health teams from metropolitan, regional and rural and remote Hospital and Health Services
- Not be participating as a sponsored site in the project
- Teams should include clinicians from the professions of occupational therapy, psychology, and social work. A minimum of two practitioners from each of the professions is desirable and there is no upper limit

Data collection at review sites

Review sites were provided with the draft aggregated task list in the form of a checklist data collection form. Participating clinicians in the review teams logged all clinical tasks they undertook in a 5 day period and matched them to the draft task list. As the data collection period was only 5 days in duration, participants could also note approximate frequencies for tasks that they would usually undertake as part of their role, but which did not occur during the data collection period (e.g. low frequency tasks). Participants could also record tasks that they undertook but which were not listed on the draft task list.

At the completion of the 5 day collection period, participants completed and submitted their individual task information to the Project Manager in a data collection tool (MS Excel spreadsheet). Information collected included:

- Frequency each task was performed
- Frequency of tasks usually performed but did not occur during the data collection period
- Any aspects of the task that were delegated or assigned
- Any additional tasks (including frequency) performed but not included on the aggregated task list

Data analysis

Data submitted from review sites was aggregated overall across sites as well as at the profession and individual team levels by the project Manager. Task frequency was averaged for and recorded using the same categories of high, moderate and low used for the project site aggregation. Additional tasks were compiled and examined.

Comparative analysis was undertaken of the data from project and review sites, particularly in regard to tasks performed.

Aggregated review site and profession data for the aggregated task list was provided back to participating teams.

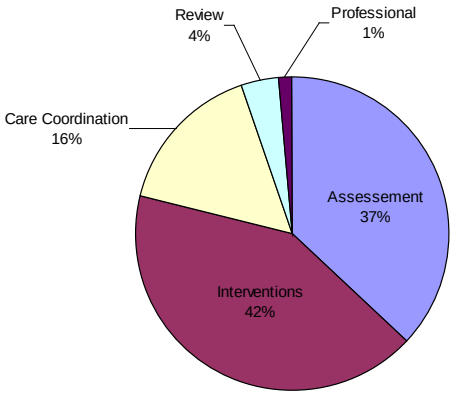
Appendix 6: Aggregated clinical task list

An aggregated list of clinical tasks was developed from the Calderdale Framework data collected from the 5 community mental health teams across the 4 project sites.

Current tasks by function area

The aggregated clinical task list has a total of 76 tasks. These were grouped into 5 broad functions to reflect the consumer pathways through community mental health services. The breakdown of tasks by function area is provided in Figure 2.

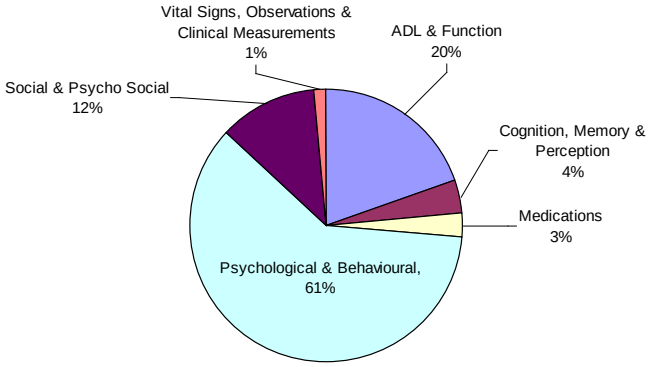
Figure 2: Aggregated task list by function area



Current tasks by clinical area

The aggregated task list was distributed across a number of clinical areas covered within current community mental health practice. This is illustrated in Figure 3.

Figure 3: Aggregated task list by clinical area



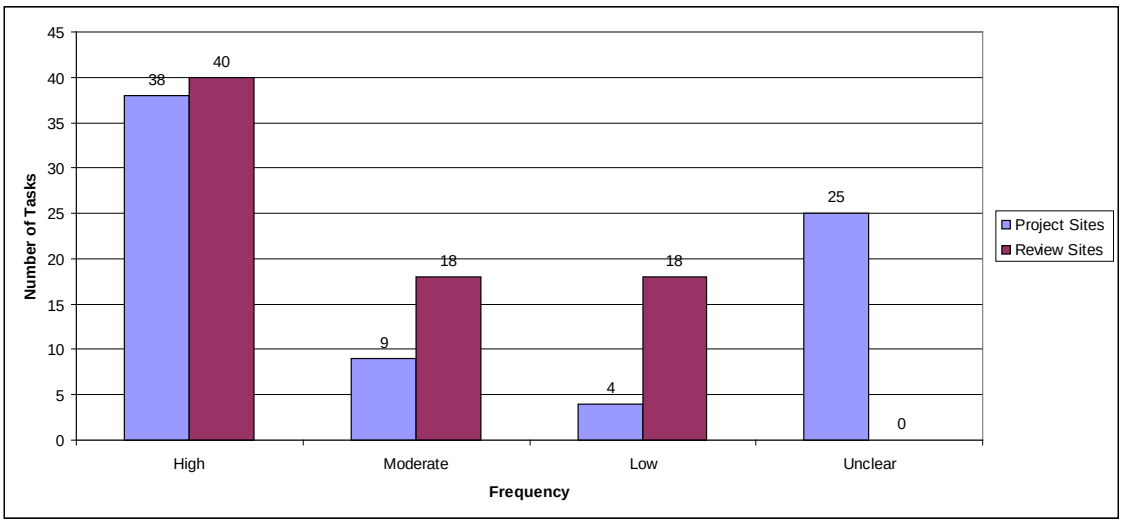
Current tasks by frequency

Task frequency was documented by both project and review sites and average frequency was recorded as outlined below:

- High frequency Task occurs at least once a week
- Moderate frequency Task occurs less than weekly but more than monthly
- Low frequency Task occurs monthly or less

It must be noted that due to the expansion and / or aggregation of raw task data from the project sites – it was not possible in all instances for the frequency of a task to be accurately determined. In these instances, the frequency is recorded as unclear. Comparative data from the project and review sites is provided in Figure 4.

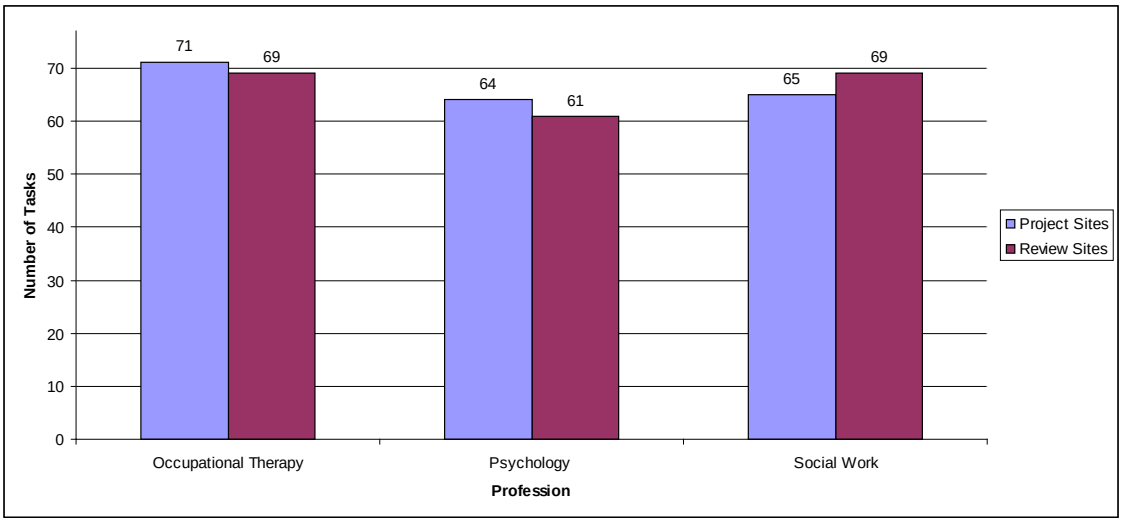
Figure 4: Comparison of task frequency at project and review sites



Current tasks by Allied Health Profession

Data on the tasks in the aggregated list currently performed by the professions of occupational therapy, psychology, and social work was collected at both project and external review sites. Comparative data for each grouping of the project and review sites is provided in Figure 5.

Figure 5: Comparison of Tasks Performed by Profession at Project and Review Sites



The multi-professional delivery of clinical tasks and functions within community adult mental health practice is also reflected in Figure 6. It is however difficult to ascertain whether a task is multi-professional because it sits within the accepted scope of practice of a number of professions or has resulted due to skill sharing at the local site levels. How a task came to be provided by more than one profession at either project or review sites is outside the scope of this project to determine.

Figure 6: Comparison of task delivery at project and review sites

Task analysis findings

Task analysis decisions

Task analysis decisions from the project sites identified that the majority of clinical tasks (64 per cent) should remain with the professions currently delivering the task (refer Figure 7). Tasks suggested from site data as potentially suitable for skill sharing with other professions were either already being performed by the three professions at that or other sites or were performed by a discipline outside the project scope (such as nursing). The lack of tasks identified for skill share could be a reflection of the perceived existing multidisciplinary delivery of tasks or interpreted as a need for more structured training and competency assessment around these tasks to maximise quality and safety.

Delegation

A total of 27 tasks (36%) out of the 76 listed were identified as potentially appropriate for delegation to a clinical support worker. This is also likely the result of the relatively high number of tasks already perceived to be delivered by more than one profession. Most tasks identified for delegation related to: screening assessment; ADL functional training; social skills training; relaxation and mindfulness therapies as well as psycho-education on sleep hygiene and basic nutrition and exercise. Please refer to Figures 8 and 9 for a breakdown of delegation decisions by clinical function and clinical areas.

Figure 7: Task analysis decisions

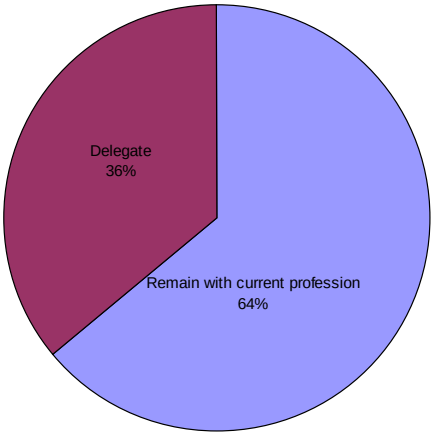


Figure 8: Proposed task delegation by clinical function

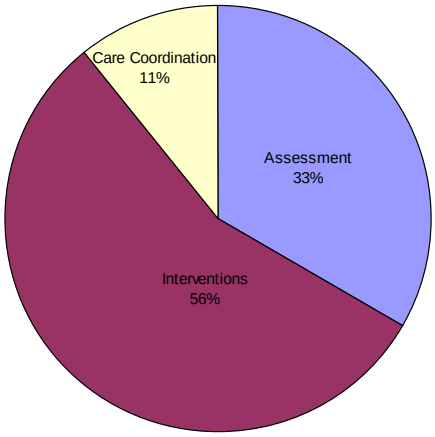
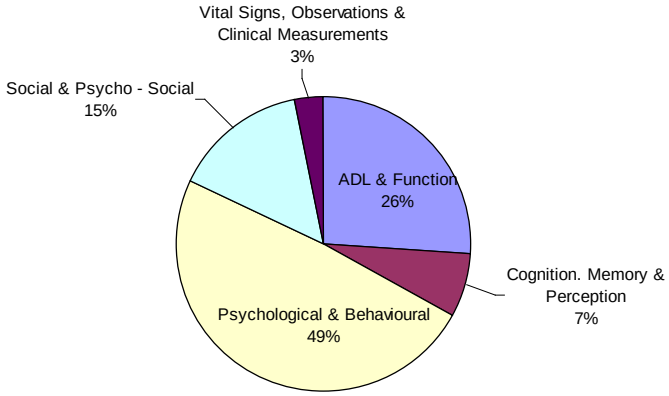


Figure 9: Proposed task delegation by clinical area



Appendix 7: Aggregated non clinical task list

Although not in the scope of the project, project sites identified a number of non- clinical tasks that are linked to their practice within community adult mental health services. These are broadly categorised under the following functions:

- Administrative / Operational
- Operational
- Professional

The list of non-clinical tasks identified by project sites is provided in Table 1. Please note that this list is not intended to present an exhaustive list of non-clinical activities that staff in community adult mental health services undertake.

Table 1: Aggregated Non Clinical Task List from Project Sites

Task Title	Task Description
Workload planning / management	Sending and responding to email, making and returning phone calls, faxing and copying documentation, prioritising tasks and planning / managing appointments / calendar
Client File Management	Transporting (location and delivery) of client files to other MDT members or service providers. Ensuring information updated.
Client Transport	Arranging client transport including car (booking, collecting, refuelling and documenting mileage) or other transport arrangements for client (community bus, taxi) driving clients to and from appointments.
Client Appointments	Scheduling and confirming appointments with service providers and client / family / carer. Confirming with provider that client attended
Meeting Coordination	Coordinating meetings including room / venue booking, sending meeting appointments, development and distribution of meeting materials, booking videoconference / teleconference and other equipment, writing up minutes.
Medication Delivery	Collection of client scripts from GP / pharmacy, collecting filled prescriptions and delivering to client / GP (Depot).
New Client Intake	Entry of new client details (demographics) onto service systems and allocation to Case Manager
Providing Professional Supervision	Providing professional supervision to staff and / or students on placement
Professional / Discipline Specific Meetings	Preparation and participation in discipline specific meetings within service
Team / Unit Meetings	Preparation and participation in team / unit meetings
CPD Requirements	Participation in education and other activities to meet profession CPD requirements
Mandatory Training	Participation and completion of mandatory general and specific training requirements as determined by service
HR Requirements	Completion of HR requirements including timesheets, rosters, and leave and other documentation
QA, Evaluation and Research Activities	Participation in QA (audit / reviews), evaluation and research projects / activities (either as participant / investigator)
Service Accreditation	Preparation / Participation in service accreditation activities.

Appendix 8: Occupational Therapy findings

Sample

A total of 16 Occupational Therapists participated in the project: 8 from project sites and 8 from review sites respectively.

Current clinical tasks

At project sites, occupational therapy were involved in the delivery of 71 (93%) out of the 76 clinical tasks listed. At review sites, occupational therapy delivered 69 out of the 76 (91%) clinical tasks listed. The spread of tasks delivered by functional and clinical areas at the respective project and review sites are illustrated in Figures 10 and 11.

Figure 10: Occupational Therapy Delivery of Clinical Function Tasks at Project and Review Sites

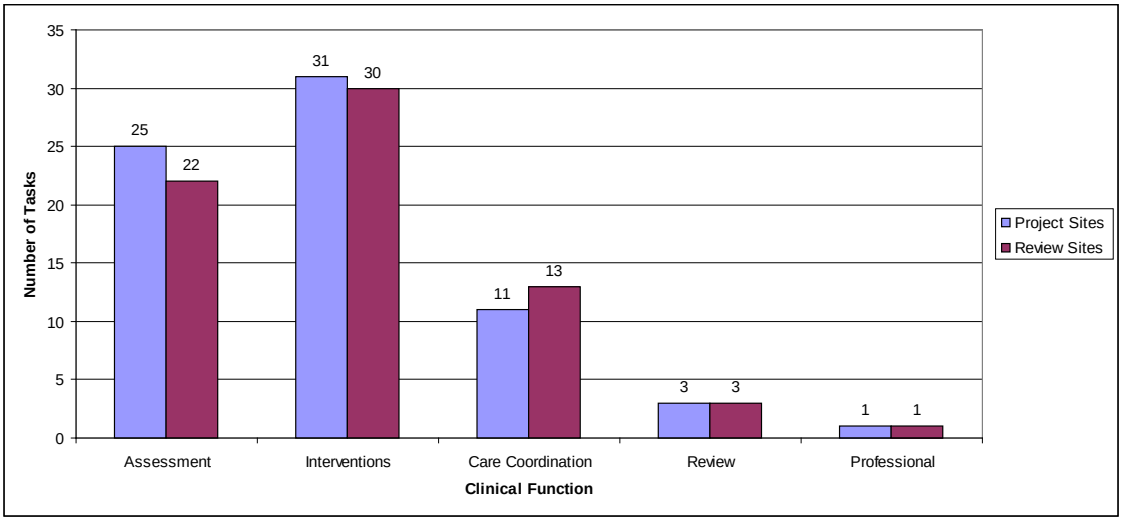
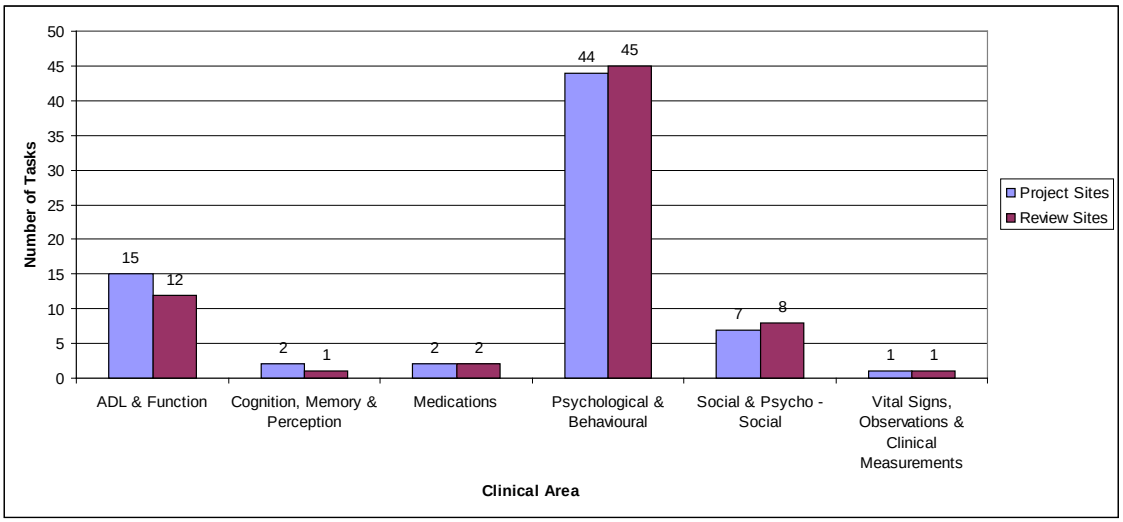


Figure 11: Occupational Therapy Delivery of Clinical Area Tasks at Project and Review Sites



Additional tasks

One occupational therapist from the review sites identified additional tasks which either fell into operational / administration and professional functional areas or were already within the scope of the aggregated task list.

Task analysis decisions

Of the 27 tasks identified as suitable for delegation, all were currently being performed by occupational therapists at project sites.

Appendix 9: Psychology findings

Sample

A total of 11 Psychologists participated in the project: 6 from project sites and 5 from review sites respectively.

Current clinical functions and tasks

At project sites, psychology were involved in the delivery of 64 (84%) out of the 76 clinical tasks listed. At review sites, psychology delivered 61 (80%) out of the 76 clinical tasks listed. The spread of tasks delivered by functional and clinical areas at the respective project and review sites are illustrated in Figures 12 and 13.

Figure 12: Psychology Delivery of Clinical Function Tasks at Project and Review Sites

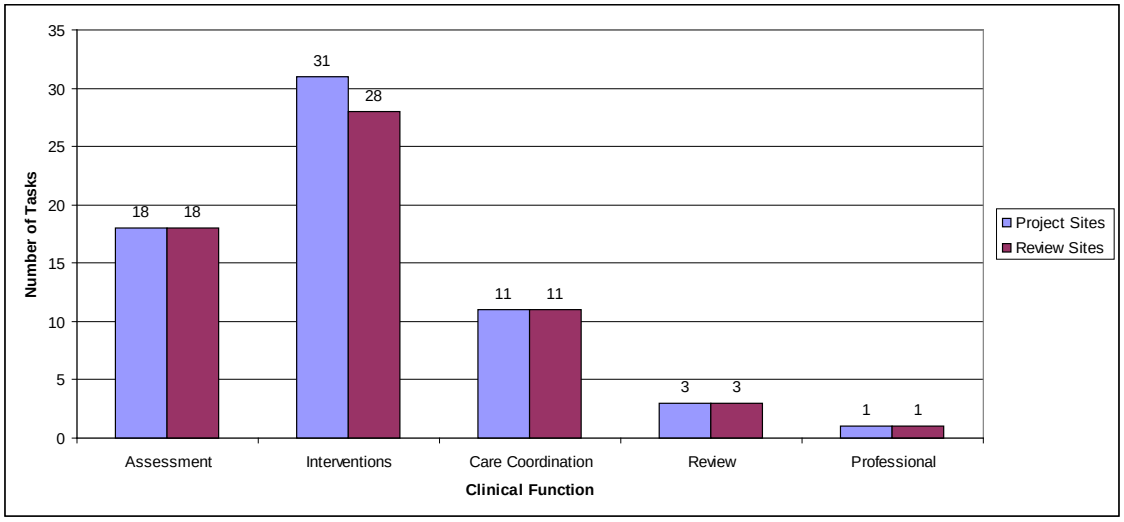
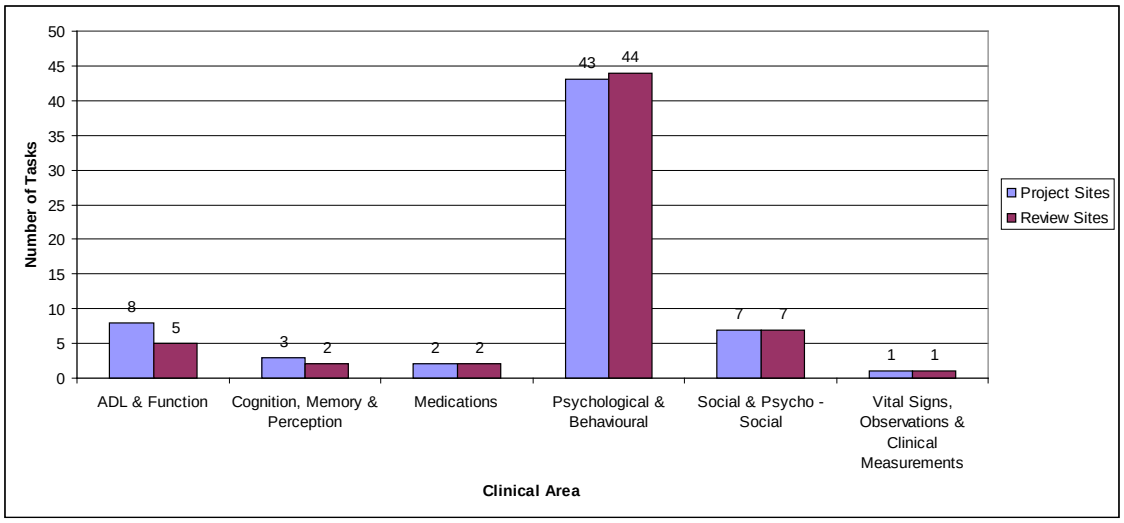


Figure 13: Psychology Delivery of Clinical Area Tasks at Project and Review Sites



Additional tasks

Two psychologists from review sites identified a number of additional tasks which either fell into operational / administration and professional functional areas or were already within the scope of the aggregated task list. Only two additional tasks were identified for potential inclusion into aggregated task list: cognitive remediation group and Adaptive Behaviour Assessment.

Task analysis decisions

Twenty six (26) of the 27 tasks identified as suitable for delegation were currently being performed by psychologists at project sites.

Appendix 10: Social Work findings

Sample

A total of 24 Social Workers participated in the project: 16 from project sites and 8 from review sites respectively.

Current clinical functions and tasks

At project sites, social workers were involved in the delivery of 65 (86%) out of the 76 clinical tasks listed. At review sites, social workers delivered 69 out of the 76 (91%) clinical tasks listed. The spread of tasks delivered by functional and clinical areas at the respective project and review sites are illustrated in Figures 14 and 15.

Figure 14: Social Work Delivery of Clinical Function Tasks at Project and Review Sites

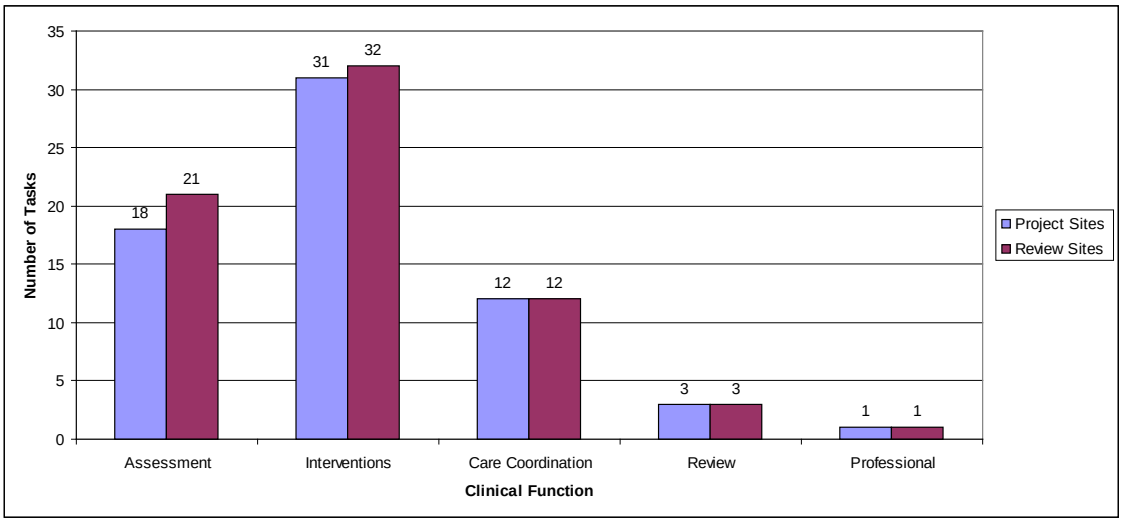
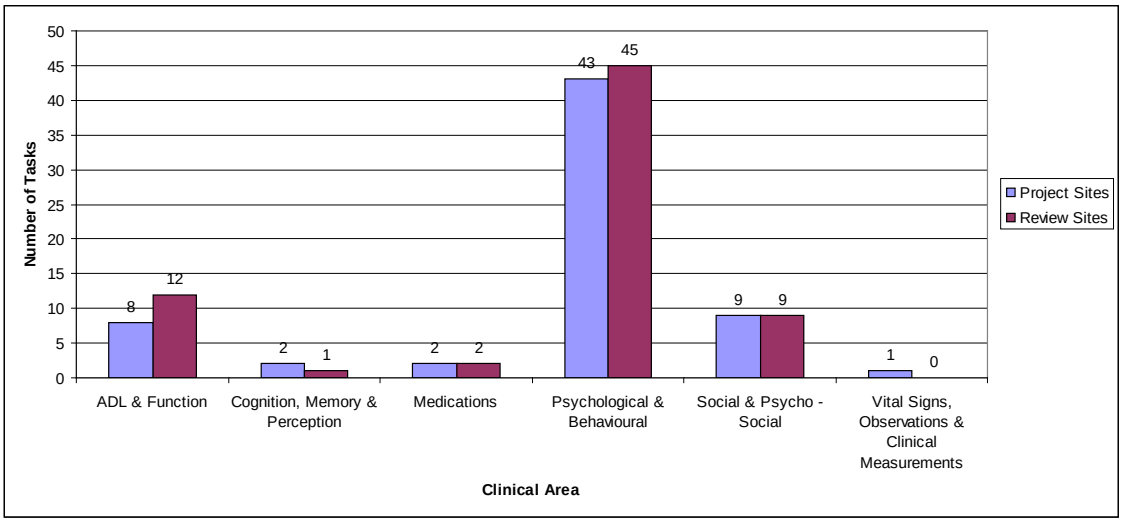


Figure 15: Social Work Delivery of Clinical Area Tasks at Project and Review Sites



Additional tasks

One social worker from the review sites listed a number of additional tasks that either fell into operational / administration and professional functional areas or were already within the scope of the aggregated task list. Only two activities were identified for potential inclusion into aggregated task list: functional vocational assessment and gambling psycho-education.

Task analysis decisions

Of the 27 tasks identified as suitable for delegation, all were currently being performed by Social Workers at project sites.

Appendix 11: Allied Health Expert Review

Methodology

Membership

Members were identified and invited to participate based on the following criteria:

- Senior practising clinicians within a Queensland Hospital and Health Service from the occupational therapy, psychology, and social work professions (2 from each profession)
- Senior academics from the tertiary education sector from the professions of occupational therapy, psychology, and social work (2 from each profession)

Expert Review Workshops

Members undertook an hour long orientation session to familiarise themselves with the workshop processes and materials prior to participating in one of two 3 hour interdisciplinary workshops. Members were provided with the aggregated task list generated from the project sites, including task analysis decisions relating to the appropriateness of a task to:

- Remain with the current profession(s)
- Be skill shared between professions in the team
- Be delegated to an clinical support worker (e.g. allied health assistant)
- Be assigned to a non-clinical support worker

Reviewers provided specific advice with regard to:

- anomalous data within the task list with regard to clinical tasks currently undertaken by allied health professionals delivering adult community mental health services, focusing on occupational therapy, psychology, and social work (e.g. appropriateness and scope of tasks, professions involved in delivery); and
- rating the potential value for clients and health services of implementing the task delegation / assignment / skill share decisions provided by project sites based on the following criteria:
    - » quality and safety
    - » health outcomes
    - » efficiency
    - » access
    - » job satisfaction

Workshop data was collated and analysed by the Project Manager and integrated with the key findings and recommendations for the final project report.

Allied Health Expert Review Findings

Content and Scope of Task List

Feedback from the expert review was that the tasks included in the aggregated list were appropriate for the adult community mental health context. Tasks covered a range of functions and clinical areas that underpinned the case management model of service delivery and would be considered within the current practice scope for allied health professions.

However, the aggregated list was not perceived by expert reviewers as reflective of the full scope of practice within community mental health or the respective allied health professions. Examples of identified gaps in the task list included an absence of cognitive interventions and assessment relating to the vocational / leisure domains.

Expert reviewers agreed that profession scope of practice within adult community mental health was influenced by the case management model of service delivery as well as localised service context.

Task Delivery

In relation to the delivery of clinical tasks on the aggregated list, the expert reviewers were surprised at the high number of tasks delivered by multiple professions. The accepted shared practice of a number of generic mental health tasks across the professions (such as mental health assessment, clinical formulation, risk assessment and recovery planning) was identified as a likely cause. There was however instances of tasks being delivered by a profession that fell outside their expected or traditional scope of practice (e.g. the involvement of psychology in personal ADL functional training). This is likely the result of localised skill share arrangements.

Suitability and Value of Task Analysis Decisions

Variation in the level and detail of data provided to describe some clinical tasks made it difficult to determine whether the entire task or only a portion of the task related to the task analysis decision. This also affected the capacity of the expert reviewers to determine the value of the task analysis decisions.

For those tasks that clearly identified the extent of the task analysis decision, expert reviewers saw value in the delegation of a range of screening assessments (e.g. physical functioning, cognition), housing and accommodation support and subjective history taking. It was noted however that these tasks were often performed as a discrete element of a broader clinical tasks such as mental health or social and environmental assessments.

The delegation of facilitating client engagement and access to health and social support services and functional training in personal, domestic and instrumental ADLs was also seen as valuable.

Expert reviewers identified some potential risks associated with the delegation of a number of assessment measures and therapeutic interventions. These included:

- outcomes measures (MHI & HoNOS);
- cognitive assessments (MOCA & MMSE);
- mindfulness and relaxation therapies and psycho-education;
- motivational interviewing and brief interventions
- social skills training

This was based on concerns of the expert reviewers about the appropriate use of assessment tools and therapeutic interventions in line with current evidence based practice guidelines, especially in light of the high level of multi-profession delivery identified within the project and the potential for delegation.

Expert reviewers suggested that further work would be needed to identify other factors that may impact the decision to delegate including:

- regulatory restrictions on the administration and interpretation of assessment tools and measures; and
- business / operational rules or organisational policies around tasks such as access, entry and verification of client data into clinical information management systems.

Attachment 1 - Full Task List

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Psychology	Social Work
Assessment							
AD001	[AD001] (ADL & Function) Screening Assessment - Physical Functioning	Subjective screening assessment of health issues including physical signs and symptoms such as pain, weakness and bowel and bladder function. May include sourcing information from medical record, investigations, client, family / carer	1	High	✓	✓	✓
AD002	[AD002] (ADL & Function) Screening Assessment - Personal, Domestic & Instrumental ADL	Subjective screening assessment on client performance including level of independence / support of: (1) Personal ADL including grooming, toileting, bathing , dressing, sleeping (2) Domestic ADL including cooking, cleaning, laundry and (3) Instrumental ADL including shopping, budgeting, accessing community services and transport	5	High	✓	✓	✓
AD003	[AD003] (ADL & Function) Functional Assessment - Personal ADL	Functional objective assessment of client capacity to complete personal ADL including toileting, bathing and dressing. Includes use of specific assessment tools such as Allen Cognitive Level Screen (ACLS). To be used for clients with problems with tasks reported on subjective assessment and minor moderate physical, perceptual or cognitive issues are likely to be impacting the safety and independence of these activities. Indicated if ADL tasks are not primary focus of presenting condition and service referral. Precedes comprehensive personal ADL assessment	5	Moderate	✓		
AD004	[AD004] (ADL & Function) Functional Assessment - Domestic ADL	Functional objective assessment of client capacity to complete domestic ADL including cooking, cleaning and laundry. Includes use of specific assessment tools such as Allen Cognitive Level Screen (ACLS) and Domestic and Community Skills Assessment (DACSA). To be used for clients with problems with tasks reported on subjective assessment and minor - moderate physical, perceptual or cognitive issues are likely to be impacting the safety and independence of these activities. Indicated if ADL tasks are not primary focus of presenting condition and service referral. Precedes comprehensive domestic ADL assessment.	5	Moderate	✓		
AD005	[AD005] (ADL & Function) Functional Assessment - Instrumental ADL	Functional objective assessment of client capacity to complete instrumental ADL including shopping, budgeting, shopping, accessing community services and transport. Includes use of specific assessment tools such as Allen Cognitive Level Screen (ACLS), Domestic and Community Skills Assessment (DACSA) and Instrumental Activities of Daily Living Scale (IADL). To be used for clients with problems with tasks reported on subjective assessment and minor - moderate physical, perceptual or cognitive issues are likely to be impacting the safety and independence of these activities. Indicated if ADL tasks are not primary focus of presenting condition and service referral. Precedes comprehensive domestic ADL assessment.	5	Moderate	✓		

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
AD006	[AD006] (ADL & Function) Comprehensive Assessment - Personal, Domestic and Instrumental ADL	Comprehensive objective assessment of client's capacity to complete: (1) personal ADL including grooming, toileting, bathing, dressing (2) Domestic ADL including cooking, cleaning, laundry and (3) Instrumental ADL including shopping, budgeting. Includes use of specific assessment tools such as Allen Cognitive Level Screen (ACLS), Domestic and Community Skills Assessment (DACSA) and Instrumental Activities of Daily Living Scale (IADL). To be used for clients with complex physical, perceptual or cognitive issues impacting the safety and independence of these activities. Indicated if assessment outcomes have significant influence on client care plan.	3	Moderate	✓		
AD007	[AD007] (ADL & Function) Functional Assessment in Home Environment	Functional assessment of client level of functioning within home environment with a focus on safety and independent capacity to mobilise, transfer and access all areas of the home required activities of daily living - bathroom and toilet, kitchen and access areas. Observation of client in all relevant areas of home - bathroom and toilet, kitchen and access areas. Includes both physical environment assessment focused on safety, hazard identification and functional assessment of client ability to access required areas of the dwelling.	3	High	✓	✓	✓
AD008	[AD008] (ADL & Function) Comprehensive Assessment in Home Environment	Comprehensive assessment of functioning within the home environment with a focus on safety , independent capacity to complete activities of daily living , relevance of assessment findings for care planning and diagnosis and potential for improving performance through rehabilitative program, equipment or services. Assessment includes recording (including measuring) bathroom and toilet set up, kitchen layout and equipment, existing home modifications and access.	1	High	✓		
AD009	[AD009] (ADL & Function) Assessment of the Home Environment - Minor Modifications	Assessment of the home environment with reference to client functional capacity, independence and safety for the purpose of determining need for minor environmental adaptation / modifications.	2	Moderate	✓		
AD010	[AD010] (ADL & Function) Assessment of the Home Environment - Major Modifications	Assessment of the home environment with reference to client functional capacity, independence and safety for the purpose of determining need for major environmental adaptation / modifications.	2	Low	✓		

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
CP001	[CP001] (Cognition, Perception & Memory) Screening assessment - cognition	Subjective screening assessment of client's cognition using medical records, discussions with carer/family, other clinicians and staff working with the client (aged care, school, clinic, etc.).	4	High	✓	✓	✓
CP002	[CP002] (Cognition, Perception & Memory) Cognition assessment using standardised tools: MOCA, ACLS, ACER, DAS, MMSE	Formal assessment of client's cognitive capacity. Includes use of one or more standardised tests, most commonly Montreal Cognitive Assessment (MOCA), Allen Cognitive Levels Screen (ACLS), Cognisant, Addenbrookes Cognitive Examination (ACER), Differential Ability Scale (DAS) and Mini Mental State Examination (MMSE).	4	High	✓	✓	✓
CP003	[CP003] (Cognition, Perception & Memory) Cognition assessment using standardised tools: WAIS, NuCog, & DKEF -S	Formal assessment of client's cognitive capacity. Includes use of Weshsler Adult Intelligence Scale (WAIS), NuCog & Delis - Kaplan Executive Function System (DKEF - S)	4	Moderate		✓	
ME001	[ME001] (Medications) Screening assessment - medications	Subjective screening assessment of client current medications, including reported side effects, symptom management, compliance and access.	5	High	✓	✓	✓
PB001	[PB001] (Psychological & Behavioural) Subjective history taking	Identify and collect information / collateral relating to client history through interviews with client, family / carers, health professionals and other significant people and review of medical records / other documentation. Areas include: presenting problem and relevant history, current functioning, relevant cultural and social issues, psychiatric history (previous assessments and interventions both personal and family), medical history (including current medications), family, developmental and legal / forensic history, risk screen and mental status examination.	2	High	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
PB002	[PB002] (Psychological & Behavioural) Mental Health Assessment	Comprehensive assessment of client mental health involving clinical interview and assessment. Areas included in assessment are: presenting problem and relevant history, current functioning, relevant cultural and social issues, psychiatric history (previous assessments and interventions both personal and family), medical history (including current medications), family, developmental and legal / forensic history, risk screen and mental status examination. Can include use of standardised assessments. Informs the development of a clinical formulation and recovery management planning.	5	High	✓	✓	✓
PB003	[PB003] (Psychological & Behavioural) Screening assessment - psychiatric disorders	Formal objective assessment of client for psychological disorders including depression, schizophrenia and anxiety. Includes use of standardised tools including: Differential Ability Scale (DAS); Brief Psychiatric Rating Scale (BPRS); Beck Depression Inventory (BDI); Beck Anxiety Inventory (BAI) and Montgomery Asberg Depression Rating Scale (MADRAS).	3	High	✓	✓	✓
PB004	[PB004] (Psychological & Behavioural) Mental State Assessment	Assessment and documentation of client mental state and functioning including appearance, behaviour, speech, speech and thought content, mood and affect, perception, cognition and insight. Includes use of standardised assessment tools such as Mini Mental State Examination (MMSE) and Mental State Examination (MSE).	5	High	✓	✓	✓
PB005	[PB005] (Psychological & Behavioural) Risk Assessment	Assessment and documentation of client static, dynamic and protective risk factors in relation to suicide and self-harm violence / aggression, vulnerability, absconding, child protection. Informs development of clinical formulation and clinical decision making for recovery management planning.	4	High	✓	✓	✓
PB006	[PB006] (Psychological & Behavioural) Screening Assessment-Drug & Alcohol	Screening and documentation of client alcohol and drug use, including frequency and level of risk. Can include use of standardised tools including Alcohol Use Disorders Identification test (AUDIT) and Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Informs development of clinical formulation and clinical decision making for recovery management planning.	3	High	✓	✓	✓
PB007	[PB007] (Psychological & Behavioural) Personality Assessment (PAI, MMPI, SCIDS)	Assessment and documentation of adult personality and psychopathology using standardised tools including the Personality Assessment Inventory (PAI), Minnesota Multiphasic Personality Inventory (MMPI) & Structured Clinical Interview for DSM Disorders (SCIDs). Provides relevant information for clinical diagnosis, treatment planning and screening for psychopathology. Informs development of clinical formulation and recovery management planning.	3	Moderate		✓	

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Current discipline: Psychology	Current discipline: Social Work
PB008	[PB008] (Psychological & Behavioural) Screening Assessment - Physical Health	Subjective assessment of client physical health and identification of risk factors including co morbidities, sexual health, oral health, smoking and obesity.	1	High	✓		✓
PB009	[PB009] (Psychological & Behavioural) Sensory Assessment	Assessment of client processing of sensory information from the environment including visual, auditory, tactile, taste, olfactory, proprioception and vestibular system. Used to identify sensory modulation, motor and discrimination disorders. Includes use of observation strategies, standardised tests and questionnaires.	1	Low	✓		
PB010	[PB010] (Psychological & Behavioural) Clinical Formulation	Documentation of comprehensive clinical summary of mental health assessment using a bio psycho social framework / model. Formulation includes information about predisposing, precipitating, perpetuating and protective factors relevant to client presentation, diagnosis, prognosis and current risks. Informs the development of recovery management planning.	1	High	✓	✓	✓
SP001	[SP001] (Social & Psycho-Social) Screening Assessment - Social and Environment	Subjective screening assessment of client t social and environmental interactions, potential risks, supports and limitations.	3	High	✓	✓	✓
SP002	[SP002] (Social & Psycho-Social) Social and Environment Assessment	Comprehensive formal assessment of specific client social and environmental interactions using standardised psycho – social assessment measures.	2	High			✓
SP003	[SP003] (Social & Psycho-Social) Parenting / Child Safety Assessment	Assessment of level of risk for children with parent(s) under the care of mental health services. Areas of assessment include: the identification of risk and protective factors for the adult client, child or young person being cared for and the social and physical environment. Documentation of assessment outcomes informs development of Family Support Plan and Child Care Plans.	2	High	✓	✓	✓
VS001	[VS001] (Vital Signs, Observations & Clinical Measurements) Metabolic Monitoring	Provide physical assessment and measurements for the purposes of metabolic monitoring (BP, Ht, Wt, girth measurement)	5	High	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
Intervention							
AD011	[AD011] (ADL & Function) Functional Training - Personal ADL (grooming, toileting, bathing, dressing)	Training of safe and efficient ways to perform personal ADL tasks including grooming, toileting, bathing and dressing. Can include practice with instruction and demonstration, prompting, assistance or supervision with the emphasis on encouraging independence. Training may include use of, compensatory strategies, positioning, and adjustment of environment.	5	Unclear due to expansion	✓	✓	✓
AD012	[AD012] (ADL & Function) Functional Training - Domestic ADL (Cooking)	Training of safe and efficient ways of cooking and meal preparation to optimise function. Can include practice with instruction and demonstration, prompting, assistance or supervision with the emphasis on encouraging independence. Training may include use of compensatory strategies, positioning, and adjustment of environment, cognitive and perceptual training techniques and compensatory strategies.	3	Unclear due to expansion	✓	✓	✓
AD013	[AD013] (ADL & Function) Functional Training - Domestic ADL (Cleaning, Laundry)	Training of safe and efficient ways to carry out cleaning and laundry to optimise function. Strategies may include functional retraining, task modification strategies, and use of supporting services.	3	Unclear due to expansion	✓	✓	✓
AD014	[AD014] (ADL & Function) Functional Training - Instrumental ADL (Transport)	Training of safe and effective ways to access transport and research transport options to build and promote client independence. Strategies may include functional retraining, task modification strategies, and use of supporting services.	3	Unclear due to expansion	✓	✓	✓
AD015	[AD015] (ADL & Function) Functional Training - Instrumental ADL (Shopping, Budgeting)	Training of safe and effective ways to carry out basic shopping and budgeting to optimise function. Strategies may include functional retraining, task modification strategies, and use of supporting services.	3	Unclear due to expansion	✓	✓	✓
PB013	[PB013] (Psychological & Behavioural) Recovery Management Plan	Implementation of client recovery management plan. This can include referral and liaison with relevant service providers, provision of agreed interventions (by practitioner or other service provider), client advocacy and management review.	4	High	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
PB014	[PB014] (Psychological & Behavioural) Crisis Intervention Plan	Implementation of crisis support interventions and strategies outlined in client recovery plan when client has deteriorated or is in acute distress. Strategies include early identification / prevention of relapse, de-escalation techniques, and activation of advanced health directives. Can involve emergency services (police / ambulance / ED), Acute Care Team or other social support services and resources.	4	High	✓	✓	✓
PB023	[PB023] (Psychological & Behavioural) Mental Health Act	Provision of information to client, family / carer about their rights and responsibilities under the Mental Health Act, identification of appropriate contacts and ensure client knows how to access contacts and obtain information.	1	High	✓	✓	✓
PB024	[PB024] (Psychological & Behavioural) Sensory Modulation	Provide sensory modulation techniques and sensorimotor activities to clients to manage stress / arousal related to internal physiology.	1	Low	✓		
PB025	[PB025] (Psychological & Behavioural) Mindfulness Therapy	Provide therapy to clients using mindfulness techniques to reduce levels of client stress and promote wellbeing that divert client focus on present moment rather than unhelpful thoughts and feelings.	3	Unclear due to expansion	✓	✓	✓
PB026	[PB026] (Psychological & Behavioural) Relaxation Therapy	Provide therapy to clients using physical relaxation techniques including slow breathing exercises and progressive muscle relaxation.	2	Unclear due to expansion	✓	✓	✓
PB027	[PB027] (Psychological & Behavioural) Systemic Therapies	Provision of systemic based therapies to clients on an individual basis to improve their relationships and interactions with family members, carers and significant others. Techniques include Narrative Therapy, Art Therapy and Play Therapy.	4	Unclear due to expansion	✓	✓	✓
PB028	[PB028] (Psychological & Behavioural) Cognitive Behavioural Therapies (CBT)	Provide CBT based therapies to clients to develop personal coping strategies to solve current problems and change patterns in cognition, behaviours and emotional regulation. Related therapies include: Brief Cognitive Behavioural Therapy (BCBP); Cognitive Emotional Behavioural Therapy (CEBT); Structured Cognitive Behavioural Training (SCBT), Dialectical Behavioural Therapy (DBT), Acceptance and Commitment Therapy (ACT) and Rational Emotive Behaviour Therapy (REBT).	4	Unclear due to expansion	✓	✓	✓
PB029	[PB029] (Psychological & Behavioural) Interpersonal Therapy (IPT)	Provide IPT based therapies to clients to improve interpersonal functioning and increase social support through identification, understanding, modification and management of interpersonal / relationship problems.	4	Unclear due to expansion	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
PB030	[PB030] (Psychological & Behavioural) Brief Intervention / Motivational Interviewing	Provide brief interventions / motivational interviewing approaches with clients to initiate change in unhealthy or risky behaviours such as smoking, alcohol and other drug use.	3	Unclear due to expansion	✓	✓	✓
PB031	[PB031] (Psychological & Behavioural) Family / Couple Therapies	Provide family based therapies, stress management and support to clients and their families / carers to improve the relationships and interactions of family members / carers / significant others using the following techniques: structural therapy (identification and re-order of family system); strategic therapy (patterns of interaction between family members); systemic therapy (focus on belief systems); narrative therapy (separation of the problem from the person) and trans-generational therapy (trans-generational transmission of unhelpful belief and behaviour patterns). Also known as Couple / Family Therapy, Family Systems Therapy.	4	Unclear due to expansion	✓	✓	✓
PB032	[PB032] (Psychological & Behavioural) Psychotherapies	Provide insight oriented psychotherapies to clients to increase self-awareness and understanding of the underlying causes (thoughts / beliefs, feelings and behaviours) for current problems and developed response patterns. Related psychotherapies include Insight Oriented Therapy (IOT), Psychodynamic Therapy.	4	Unclear due to expansion		✓	✓
PB033	[PB033] (Psychological & Behavioural) Group based therapies	Assessment of group participants, assessment of group dynamics, Development of group context/therapy and content, for example ACT group, anger management, grief and loss. Facilitation of group therapy.	4	Unclear due to expansion	✓	✓	✓
PB034	[PB034] (Psychological & Behavioural) Psycho Education - Relaxation	Provide education (knowledge, skills and strategies) to clients on physical relaxation techniques including slow breathing exercises and progressive muscles relaxation.	5	Unclear due to expansion	✓	✓	✓
PB035	[PB035] (Psychological & Behavioural) Psycho Education - Mindfulness	Provide education (knowledge, skills and strategies) to clients on mindfulness exercises and activities to reduce stress and promote wellbeing.	5	Unclear due to expansion	✓	✓	✓
PB036	[PB036] (Psychological & Behavioural) Psycho Education – Nutrition and Exercise	Provide education (knowledge, skills and strategies) to clients on basic nutrition and physical exercise activities, link clients into exercise/leisure groups in the community. Information provided relates to population level best practice advice for community members.	2	Unclear due to expansion	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
PB037	[PB037] (Psychological & Behavioural) Psycho Education - Sleep Hygiene	Provide education (knowledge, skills and strategies) to clients for improved sleep hygiene including use of sleep plans.	3	Unclear due to expansion	✓	✓	✓
PB038	[PB038] (Psychological & Behavioural) Psycho Education - Medication Management	Provide education (knowledge, skills and strategies) to clients on medications including instructions on use / recommended dosage, administration, possible side effects and compliance.	4	Unclear due to expansion	✓	✓	✓
PB039	[PB039] (Psychological & Behavioural) Psycho Education – Psychological Condition Management	Provide education (knowledge, skills and strategies) to clients on psychological condition(s), symptom management treatment options and relapse prevention.	5	Unclear due to expansion	✓	✓	✓
PB040	[PB040] (Psychological & Behavioural) Psycho Education - Drug and Alcohol	Provide education (knowledge, skills and strategies) to clients on alcohol and other drugs, effects of use and harm reduction strategies.	3	Unclear due to expansion	✓	✓	✓
PB041	[PB041] (Psychological & Behavioural) Psycho Education - Coping Skills	Provide education (knowledge, skills and strategies) to clients build resilience. Examples include: crisis and stress management, Hearing Voices program.	4	Unclear due to expansion	✓	✓	✓
PB042	[PB042] (Psychological & Behavioural) Psycho Education – Psychological Condition Management (Carer / Family)	Provide education (knowledge, skills and strategies) to family / carer on psychological condition(s), symptom management treatment options and relapse prevention.	5	Unclear due to expansion	✓	✓	✓
PB043	[PB043] (Psychological & Behavioural) Psycho Education - Medication Management (Carer / Family)	Provide education (knowledge, skills and strategies) to carers / family on management of medications including instructions on use / recommended dosage and administration, possible side effects and compliance.	4	Unclear due to expansion	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
PB044	[PB044] (Psychological & Behavioural) Psycho Education - Sleep Hygiene (Carer / Family)	Provide education (knowledge, skills and strategies) to carer / families on sleep hygiene, including the use of sleep plans.	1	Unclear due to expansion	✓	✓	✓
SP005	[SP005] (Social & Psycho-Social) Family Support Plan and Child Care Plan	Development of a Family Support Plan and Child Care Plan in collaboration with the client and their family based on the results of the parenting / child safety assessment to be implemented if client relapses or is temporarily unable to provide care for their children.	2	Moderate	✓	✓	✓
SP006	[SP006] Social & Psycho-Social (Intervention) - Psycho Education – Family / Carer Resilience	Provide education (knowledge, skills and strategies) to family / carer to build resilience. Includes the identification of carer / family needs, strengths and barriers, support networks, resources and crisis management.	4	High	✓	✓	✓
SP009	[SP009] Social & Psychosocial (Intervention) - Skills training – Social Skills, communication, boundaries and assertiveness.	Social skills and communication training in individual and or group format. This includes how to use language, how to change your language for the social setting, how to follow the rules of conversation, and how to interpret verbal and non-verbal cues.	2	High	✓	✓	✓
Care Coordination							
ME002	[ME002] (Medications) Medication Monitoring	Coordinate and monitor client use of prescribed medications including: access and provision, compliance, medication reviews with GP / other health professionals and documentation of changes to medications.	5	High	✓	✓	✓
PB012	[PB012] (Psychological & Behavioural) Recovery Management Planning	Development of recovery management plan in collaboration with client and other stakeholders (carers / family) if agreed to by client based on results of mental health assessment and clinical formulation. Areas covered include: identification of client goals (short and long term), strengths and care preferences, strategies and interventions needed to achieve those goals (including crisis management), who / what services will be involved and timeframes for review.	4	High	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Current discipline: Psychology	Current discipline: Social Work
PB017	[PB017] (Psychological & Behavioural) Referral Coordination	Coordination of referrals to service providers in public, private and non-government sectors identified in Recovery Management Plan. Referrals include primary / GP care, Indigenous and CALD, mental health, general health or social support services (housing, employment). Identify appropriate services; determine eligibility criteria for referral, liaison with provider, completion of referral paperwork and confirmation of referral acceptance.	3	High	✓	✓	✓
PB018	[PB018] Psychological & Behavioural Multidisciplinary Team (MDT) Case Review	Prepare and participate in meetings with multidisciplinary team members. Document clinical discussion and decisions relating to client care and recovery management.	5	High	✓	✓	✓
PB019	[PB019] (Psychological & Behavioural) Facilitate Client Engagement & Access - Health Service Providers	Provide encouragement and support clients to engage and access health service providers as documented in client recovery plan. This includes provision of education and information about services to client and carers / family. Facilitation of attendance at appointments through provision of practical support such as scheduling and confirmation of appointments, service - client liaison and transport arrangements.	5	High	✓	✓	✓
PB020	[PB020] (Psychological & Behavioural) Stakeholder Meetings & Liaison - Health Services	Liaise, prepare and participate in meetings / case conferences with public, private, community and primary health care services involved in the provision of care and services to a client. Share clinical information and make decisions regarding treatment and management. Document outcomes and decisions	5	High	✓	✓	✓
PB021	[PB021] (Psychological & Behavioural) Stakeholder Meetings & Liaison - Government Agencies	Liaise, prepare and participate in meetings with government agencies involved in the provision of care, services or support to a client. Government agencies may include Centrelink, Public Guardian, Public Trustee, QCAT, and MHRT. Prepare and provide clinical information and professional reports to inform decision making on client care and services.	3	Moderate	✓	✓	✓
PB022	[PB022] (Psychological & Behavioural) Stakeholder Meetings and Liaison - Client & Carers	Liaise, prepare and participate in meetings with client, carer(s) and family (if agreed to by client). Provide relevant information; discuss management options, preferences and changes and document decisions and outcomes.	4	High	✓	✓	✓
PB045	[PB045] (Psychological & Behavioural) Discharge Planning	Development and ongoing monitoring of treatment goals, consumer goals, communication with GP's regarding discharge planning, end of episode summary. Collation and documentation of information into discharge plan and distribution to relevant stakeholders	2	High	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Psychology	Social Work
SP004	[SP004] (Social & Psycho-Social) Housing / Accommodation Support	Identify and facilitate linkage to appropriate local supports including services focused on the maintenance of current housing options where possible, assisting client to obtain suitable housing in an alternate location if required and providing practical support during any relocation phase.	1	Low			✓
SP007	[SP007] (Social & Psychosocial) Facilitate Client Engagement & Access - Social Support Service Providers	Facilitate client access to support services in the community as documented in client recovery plan. This includes provision of information to consumer and carers / family about services provided and how to access them, service - client liaison and provision of practical support such as scheduling and confirmation of appointments, service - client liaison and transport arrangements. This includes supporting client engagement with employment agencies.	5	High	✓	✓	✓
SP008	[SP008] (Social & Psychosocial) Stakeholder Meetings & Liaison - Social Support Services	Liaise, prepare and participate in meetings / case conferences with community services involved in the provision of social support services to a client. Share clinical information and make decisions regarding supports required and services to be provided. Document outcomes and decisions.	5	High	✓	✓	✓
Review							
PB011	[PB011] (Psychological & Behavioural) Outcome measures (MHI, LSP & HoNOS)	Completion and documentation of client results in CIMHA from outcomes measures including Mental Health Inventory (MHI), Life Skills Profile (LSP) and Health of the Nation Outcome Scale (HoNOS). Results used to monitor client progress and inform recovery management planning.	4	High	✓	✓	✓
PB015	[PB015] (Psychological & Behavioural) Recovery Mx Plan Review	Review of recovery management plan in collaboration with client and other stakeholders (carer / family) if agreed to by client as clinically required or at specified interval (3 months?). Discussion of progress against / achievement of recovery plan goals, level of client engagement with plan and development of alternate strategies / interventions to support goal achievement. Document in Care Review Summary.	4	High	✓	✓	✓
PB016	[PB016] (Psychological & Behavioural) Care Review Summary	Completion and documentation of outcomes of Recovery Management Plan Review. Can include use of Situation Background Assessment Recommendation (SBAR). Scope of reporting includes Mental Health Act status (when clinically relevant), diagnosis, next appointments, medications, child protection and treatment plans, outcomes and risk screen.	3	High	✓	✓	✓
Professional							
PB046	[PB046] (Psychological & Behavioural) Professional Supervision	Participation and provision of clinical supervision. Discussion about current clinical caseload.	2	High	✓	✓	✓

Attachment 2 - Task List Delegation

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Psychology	Social Work
Assessment							
AD001	[AD001] (ADL & Function) Screening Assessment - Physical Functioning	Subjective screening assessment of health issues including physical signs and symptoms such as pain, weakness and bowel and bladder function. May include sourcing information from medical record, investigations, client, family / carer	1	High	✓	✓	✓
AD002	[AD002] (ADL & Function) Screening Assessment - Personal, Domestic & Instrumental ADL	Subjective screening assessment on client performance including level of independence / support of: (1) Personal ADL including grooming, toileting, bathing , dressing, sleeping 2) Domestic ADL including cooking, cleaning, laundry and (3) Instrumental ADL including shopping, budgeting, accessing community services and transport	5	High	✓	✓	✓
CP001	[CP001] (Cognition, Perception & Memory) Screening assessment - cognition	Subjective screening assessment of client's cognition using medical records, discussions with carer/family, other clinicians and staff working with the client (aged care, school, clinic, etc.).	4	High	✓	✓	✓
CP002	[CP002] (Cognition, Perception & Memory) Cognition assessment using standardised tools: MOCA, ACLS, ACER, DAS, MMSE	Formal assessment of client's cognitive capacity. Includes use of one or more standardised tests, most commonly Montreal Cognitive Assessment (MOCA), Allen Cognitive Levels Screen (ACLS), Cognisant, Addenbrookes Cognitive Examination (ACER), Differential Ability Scale (DAS) and Mini Mental State Examination (MMSE).	4	High	✓	✓	✓
PB001	[PB001] (Psychological & Behavioural) Subjective history taking	Identify and collect information / collateral relating to client history through interviews with client, family / carers, health professionals and other significant people and review of medical records / other documentation. Areas include: presenting problem and relevant history, current functioning, relevant cultural and social issues, psychiatric history (previous assessments and interventions both personal and family), medical history (including current medications), family, developmental and legal / forensic history, risk screen and mental status examination.	2	High	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Psychology	Social Work
PB006	[PB006] (Psychological & Behavioural) Screening Assessment- Drug & Alcohol	Screening and documentation of client alcohol and drug use, including frequency and level of risk. Can include use of standardised tools including Alcohol Use Disorders Identification test (AUDIT) and Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). Informs development of clinical formulation and clinical decision making for recovery management planning.	3	High	✓	✓	✓
PB008	[PB008] (Psychological & Behavioural) Screening Assessment - Physical Health	Subjective assessment of client physical health and identification of risk factors including co morbidities, sexual health, oral health, smoking and obesity.	1	High	✓		✓
SP001	[SP001] (Social & Psycho-Social) Screening Assessment - Social and Environment	Subjective screening assessment of client t social and environmental interactions, potential risks, supports and limitations.	3	High	✓	✓	✓
VS001	[VS001] (Vital Signs, Observations & Clinical Measurements) Metabolic Monitoring	Provide physical assessment and measurements for the purposes of metabolic monitoring (BP, Ht, Wt, girth measurement)	5	High	✓	✓	✓
Intervention							
AD011	[AD011] (ADL & Function) Functional Training - Personal ADL (grooming, toileting, bathing, dressing)	Training of safe and efficient ways to perform personal ADL tasks including grooming, toileting, bathing and dressing. Can include practice with instruction and demonstration, prompting, assistance or supervision with the emphasis on encouraging independence. Training may include use of, compensatory strategies, positioning, and adjustment of environment.	5	Unclear due to expansion	✓	✓	✓
AD012	[AD012] (ADL & Function) Functional Training - Domestic ADL (Cooking)	Training of safe and efficient ways of cooking and meal preparation to optimise function. Can include practice with instruction and demonstration, prompting, assistance or supervision with the emphasis on encouraging independence. Training may include use of compensatory strategies, positioning, and adjustment of environment, cognitive and perceptual training techniques and compensatory strategies.	3	Unclear due to expansion	✓	✓	✓
AD013	[AD013] (ADL & Function) Functional Training - Domestic ADL (Cleaning, Laundry)	Training of safe and efficient ways to carry out cleaning and laundry to optimise function. Strategies may include functional retraining, task modification strategies, and use of supporting services.	3	Unclear due to expansion	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline		
					Occupational Therapy	Psychology	Social Work
AD014	[AD014] (ADL & Function) Functional Training - Instrumental ADL (Transport)	Training of safe and effective ways to access transport and research transport options to build and promote client independence. Strategies may include functional retraining, task modification strategies, and use of supporting services.	3	Unclear due to expansion	✓	✓	✓
AD015	[AD015] (ADL & Function) Functional Training - Instrumental ADL (Shopping, Budgeting)	Training of safe and effective ways to carry out basic shopping and budgeting to optimise function. Strategies may include functional retraining, task modification strategies, and use of supporting services.	3	Unclear due to expansion	✓	✓	✓
PB023	[PB023] (Psychological & Behavioural) Mental Health Act	Provision of information to client, family / carer about their rights and responsibilities under the Mental Health Act, identification of appropriate contacts and ensure client knows how to access contacts and obtain information.	1	High	✓	✓	✓
PB025	[PB025] (Psychological & Behavioural) Mindfulness Therapy	Provide therapy to clients using mindfulness techniques to reduce levels of client stress and promote wellbeing that divert client focus on present moment rather than unhelpful thoughts and feelings.	3	Unclear due to expansion	✓	✓	✓
PB026	[PB026] (Psychological & Behavioural) Relaxation Therapy	Provide therapy to clients using physical relaxation techniques including slow breathing exercises and progressive muscle relaxation.	2	Unclear due to expansion	✓	✓	✓
PB030	[PB030] (Psychological & Behavioural) Brief Intervention / Motivational Interviewing	Provide brief interventions / motivational interviewing approaches with clients to initiate change in unhealthy or risky behaviours such as smoking, alcohol and other drug use.	3	Unclear due to expansion	✓	✓	✓
PB034	[PB034] (Psychological & Behavioural) Psycho Education - Relaxation	Provide education (knowledge, skills and strategies) to clients on physical relaxation techniques including slow breathing exercises and progressive muscles relaxation.	5	Unclear due to expansion	✓	✓	✓
PB035	[PB035] (Psychological & Behavioural) Psycho Education - Mindfulness	Provide education (knowledge, skills and strategies) to clients on mindfulness exercises and activities to reduce stress and promote wellbeing.	5	Unclear due to expansion	✓	✓	✓

Task code	Task type and title	Task description	n sites with task	Frequency	Current discipline: Occupational Therapy	Current discipline: Psychology	Current discipline: Social Work
PB036	[PB036] (Psychological & Behavioural) Psycho Education – Nutrition and Exercise	Provide education (knowledge, skills and strategies) to clients on basic nutrition and physical exercise activities, link clients into exercise/leisure groups in the community. Information provided relates to population level best practice advice for community members.	2	Unclear due to expansion	✓	✓	✓
PB037	[PB037] (Psychological & Behavioural) Psycho Education - Sleep Hygiene	Provide education (knowledge, skills and strategies) to clients for improved sleep hygiene including use of sleep plans.	3	Unclear due to expansion	✓	✓	✓
SP009	[SP009] Social & Psychosocial (Intervention) - Skills training – Social Skills, communication, boundaries and assertiveness.	Social skills and communication training in individual and or group format. This includes how to use language, how to change your language for the social setting, how to follow the rules of conversation, and how to interpret verbal and non-verbal cues.	2	High	✓	✓	✓
Care Coordination							
PB019	[PB019] (Psychological & Behavioural) Facilitate Client Engagement & Access - Health Service Providers	Provide encouragement and support clients to engage and access health service providers as documented in client recovery plan. This includes provision of education and information about services to client and carers / family. Facilitation of attendance at appointments through provision of practical support such as scheduling and confirmation of appointments, service - client liaison and transport arrangements.	5	High	✓	✓	✓
SP004	[SP004] (Social & Psycho-Social) Housing / Accommodation Support	Identify and facilitate linkage to appropriate local supports including services focused on the maintenance of current housing options where possible, assisting client to obtain suitable housing in an alternate location if required and providing practical support during any relocation phase.	1	Low			✓
SP007	[SP007] (Social & Psychosocial) Facilitate Client Engagement & Access - Social Support Service Providers	Facilitate client access to support services in the community as documented in client recovery plan. This includes provision of information to consumer and carers / family about services provided and how to access them, service - client liaison and provision of practical support such as scheduling and confirmation of appointments, service - client liaison and transport arrangements. This includes supporting client engagement with employment agencies.	5	High	✓	✓	✓
Review							
PB011	[PB011] (Psychological & Behavioural) Outcome measures (MHI, LSP & HoNOS)	Completion and documentation of client results in CIMHA from outcomes measures including Mental Health Inventory (MHI), Life Skills Profile (LSP) and Health of the Nation Outcome Scale (HoNOS). Results used to monitor client progress and inform recovery management planning.	4	High	✓	✓	✓

State-wide Mental Health Allied Health Scope of Practice Project report

Community Adult Mental Health

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