

Canterbury

District Health Board

Te Poari Hauora o Waitaha

Specialist Mental Health Service

Proposal for Change

Adult General Mental Health Services

29 June 2011

Table of Contents

1. Introduction	3
2. Background and Current Situation	4
3. Rationale for Proposal and Issues Pointing to Change	5
4. Proposed Changes	6
4.1. Access to Adult General Services	7
4.2. Crisis Resolution and Consultation Provision.....	7
4.3. Community Mental Health Care Provision.....	8
4.4. Acute Care Provision	9
4.5. Rehabilitation Care Provision	9
4.6. Infrastructure	10
4.7. Service Leadership Structures	10
4.8. Other Service Implications	11
5. Impact on Staff	12
5.1 Staffing	12
5.2 Impact on Professional groups.....	12
5.3 Process for affected staff	13
5.4 Training	14
6. Consultation	14
7. Conclusion	15
8. Timeline.....	15
9. Appendices.....	16

From the General Manager

In releasing the Adult General Services Proposal For Change at this time, there has been serious consideration given to the impact of the Christchurch earthquakes on staff and the ongoing distress caused by aftershocks and yet more damage to homes and our city. The decision to release this Proposal for Change is based on the feedback received that many of you are aware of the Adult General Services Plan and are experiencing additional stress as you await the proposed changes. While this proposal covers extensive changes to SMHS model of care, the intention is that no staff will lose their employment as a result of this Proposal For Change.

In releasing this document at this time, I hope to reassure our staff that time will be given to consult on the proposed changes with a six week consultation and a further six weeks to review the feedback which will inform the Interim Direction of Change. There will be further time to consider this Directional Plan before the final Direction for Change is released on 21 November 2011. Our aim is to bring about positive changes to the patient journey and your experience of working with service users and their families. We invite you to participate in this consultation process and offer a variety of ways in which you can contribute your feedback and ideas.



1. Introduction

Across the Canterbury health system there is a re-orientation of services to focus on meeting the needs of the service user. This focus on the service user and their journey is having major implications on service design, professional roles, technology, information management and infrastructure design. There has already been significant change to models of care, the range and type of services provided and the location at which services are provided. Canterbury District Health Board (CDHB) wide, three key strategic service shifts are being implemented:

- The development of services that support people to take increased responsibility for their health and a change of approach within existing services to support this;
- The development of primary and community services to support people in a community-based setting and to provide a point of ongoing continuity; and
- The freeing up of secondary care services and specialist resources to be responsive to episodic events, the growing complexity of cases and the provision of support and advice to primary care.

As a key provider within the Canterbury health sector, Specialist Mental Health Services (SMHS) are reflecting CDHB wide reorientation of services into its service planning.

In June 2010, Specialist Mental Health Services released its Framework for Mental Health and Well-being 2010-2015. The vision incorporated in this framework was one of a

responsive Mental Health Service that supports the service user and their recovery, is flexible and integrated, and improves the service delivery system.

In August 2009, an internal discussion paper on adult mental health services was developed to commence discussion of how services may look in the future. That paper and subsequent feedback was incorporated into the recently circulated '**Adult Services Plan**'.

The Adult Service Plan, 31 March 2011, acknowledges that the community is the centre of care provision; that services are recovery focused and integrated so that the care provided is responsive and services are delivered in an efficient manner.

The Plan for the reconfiguration of Te Awakura Adult Inpatient Unit was approved by the CDHB in April 2011. This was a clinically led plan based on the principles of the Mental Health Framework and the Adult Services Plan.

This 'Proposal for Change' outlines the suggested changes required to provide the base from which a **Community Care Led Model** can be developed for Canterbury; a model which spans inpatient and outpatient adult specialist mental health services. The Proposal draws upon the 'Adult Services Plan' and gives the background to the proposed changes, addresses the current situation within SMHS and where the changes will be targeted. The proposal has been a clinically led planning process, developed by the Adult Services Leadership Group (appendix 1).

The proposed changes are outlined in relation to the patient journey (i.e. Access, Crisis Resolution and Consultation, Community Mental Health Care, Acute Care and Rehabilitation Care), and the impact on staff and infrastructure.

2. Background and Current Situation

SMHS is committed to positively changing the way services are delivered. SMHS seeks to more effectively target resources to provide integrated, community focussed and service user centred care.

SMHS experiences ongoing and increasing pressure on inpatient beds. The current service configuration cannot continue. If we do not change, pressure on inpatient beds will continue to increase, resulting in further difficulties in providing adequate care within safe and therapeutic environments. Service users will continue to be dissatisfied with the current approach to inpatient care and there will continue to be overcrowding and service users' sleeping over in other units.

Ongoing efforts to improve this situation cannot progress unless there is a transfer of resources to SMHS community services. This will facilitate service growth and enable mental health services to provide the necessary levels of community care when and where it is needed.

Compared with other DHB's, Canterbury has significantly fewer staff in community teams and has more inpatient beds, as demonstrated by the **National Key Performance Indicator**

(KPI) Benchmarking process. The KPI Benchmarking project has also shown that there is a compelling need for Adult General Services to redesign and refine their role within the Canterbury mental health sector.

The service developments in this document encompass significant change to service delivery models, team structures and functions, systems and infrastructure. The SMHS will work closely with its staff, unions, partners in primary health care and the Non-Government Organisation (NGO) sector in a change management process.

3. Rationale for Proposal and Issues Pointing to Change

The overall aim of this Proposal for Change is to re-orientate our health system to provide service users with care that is responsive to the individual and their family/whanau, and ensure that care is delivered close to their community.

SMHS aims to transcend traditional boundaries between providers in order to achieve the best possible health outcomes for the service user. To achieve these aims SMHS must strengthen the community mental health teams (CMHTs) and provide service delivery in line with that provided in other large centres in New Zealand.

A Proposal for Change with the scope of this proposal will be an unsettling experience for affected staff. With any proposed change there is likely to be an impact on staffing and infrastructure. SMHS aims to be transparent and timely regarding the Proposal For Change processes. It is the intention of this proposal that there will be no redundancies as a direct result of the proposed changes. It is the intention of SMHS to retain our highly skilled staff and transition or relocate (appendix 2) them to areas where there is newly identified need or redeploy (appendix 2) them to existing gaps in SMHS inpatient areas.

For staff the benefit of the proposed changes will be increased job satisfaction through the opportunity to be engaged with the service user throughout the patient journey; improved administrative processes and a reduction in repetitive documentation, upskilling and training and, for some, a variety of work rather than the focus being on one component of the patient journey.

The proposed service changes outlined in this document will support the necessary transformation of the Canterbury mental health sector and build on quality improvements occurring across the sector in every organisation. These proposed changes also address specific recommendations from the 2008 **External Review of Te Awakura**, which included the need to increase integration between SMHS services.

The re-orientation of our health service will address service user dissatisfaction with current approaches to care (apparent in satisfaction survey results and ongoing feedback from consumer and family advisors) and, at the same time, meet the Ministry of Health's expectation to provide services closer to people's own homes and away from inpatient settings.

Other large metropolitan District Health Boards have developed models of care that are more explicitly focused on meeting the needs of the service user and their family, where the central locus of care provision is in the community rather than in the hospital. This has brought about the development of a range of new functions within CMHTs and enhanced relationships with mental health NGO providers and primary health care. These new functions include:

- Teams that are mobile
- Teams that work extended hours and have a flexible approach to service delivery
- A 'crisis resolution' function within teams that supports people across a range of environments
- Accessing alternatives to acute admission such as NGO residential services. NGOs will be actively supported by specialist mental health services staff
- Home based care that maintains the service user with their traditional supports in the community

The National KPI benchmarking process has demonstrated that District Health Boards whose services are aligned in this manner, not only provide care that is more responsive to the needs of their service users and families but they are also able to support more people in their community thereby significantly reducing the need for inpatient admissions.

In addition to changed roles and functions, SMHS systems and processes will require alignment to enable flexible responses to the service user journey rather than being service focussed.

SMHS area structures and leadership will reflect the changes to the model of care delivery to ensure that robust governance is in place to oversee this new way of working.

The proposed changes are likely to have major implications for facilities across SMHS. This issue has been intensified in the aftermath of the Canterbury earthquakes, with several teams currently displaced. Appropriate and permanent accommodation for all teams will remain a priority and will be a key factor in ensuring the proposed changes have optimum impact on the quality of our service.

In addition to receiving this written proposal and inviting written feedback, there will be staff consultation meetings where the Proposal for Change will be presented for discussion.

4. Proposed Changes

The proposed changes outlined in this document originate from a shared vision within SMHS to create a recovery focused and sustainable adult general mental health service which is integrated within the wider health system, is responsive to and inclusive of service users and their families, and delivers care in the most efficient manner. Specific goals that contribute to achieving this vision include:

1. Providing an integrated service for service users.

2. Providing health care to service users in the least restrictive manner and environment.
3. Supporting primary care through improving access to specialist mental health services for advice and short term intervention.
4. Creating welcoming therapeutic environments for service users and families, whanau whatever their level of need.
5. Ensuring that staff are appropriately trained and resourced to meet the needs of service users and families, whanau.
6. Providing a service which can flexibly meet the needs of those who need short term clinical care as well as those requiring long term clinical care from the SMHS.
7. Participating in wider sector planning processes to ensure that the community and support resources match the needs of service users.

To achieve these goals, a number of changes in form and function are required. These changes are generally within the domains of **'Access'** **'Crisis Resolution and Consultation'** **'Community Mental Health Care'** **'Acute Care'** and **'Rehabilitation Care'**. The proposed changes are as follows:

4.1 Access to Adult General Services

- 4.1.1 Single Point of Entry (SPOE), Mental Health Liaison (MHL) and Adult Community frontline staff will respond to referrals and self presentations with brief assessments and appropriate interventions.
- 4.1.2 SPOE will be further developed and expand to provide enhanced telephone triage and increased support to primary care and the wider health system via consultation/liaison and advice. SPOE will support the development of Health Pathways for access to SMHS. Recommendations from the SPOE review (January 2011) as well as requirements of the psychosocial recovery plan in the aftermath of the Canterbury earthquakes will be implemented as part of this change.

4.2 Proposed Changes to Crisis Resolution and Consultation Provision

- 4.2.1 The current psychiatric emergency function will become part of an integrated crisis resolution function within CMHTs.
- 4.2.2 The primary model of service delivery for the crisis resolution function (appendix 3) will be mobile teams that visit the service user in the setting most appropriate for them. Human, vehicle and financial resources will need to be increased/ redistributed to enable this to happen.

- 4.2.3 The crisis resolution function will be a multi-disciplinary seven day a week extended service.
- 4.2.4 Hours of work will reflect SMHS intention to provide a flexible extended service.
- 4.2.5 As part of the crisis resolution function within each CMHT, team members may rotate through this function. Appropriate training may be required to enable staff to have the necessary skill set to perform a range of functions.
- 4.2.6 Combine the Mental Health Liaison Team and the Psychiatric Consultation Service to have enhanced capacity to respond to the range of needs of service users in Christchurch Hospital, including the Emergency Department.
- 4.2.7 Review provision of the crisis resolution function for those under 18 years.

4.3 *Proposed Changes to Community Mental Health Care Provision*

- 4.3.1 Increase staff numbers within CMHTs.
- 4.3.2 Expand the working hours of the multi-disciplinary CMHTs to become a seven day a week extended hours' service.
- 4.3.3 CMHTs to work closely with family, primary health care and mental health NGOs to facilitate the provision of community based alternatives to acute inpatient care.
- 4.3.4 The primary model of service delivery will be outreach into homes and community locations. It is envisaged that as the wider health system continues to evolve and as demographic changes become apparent, the various outreach locations may change.
- 4.3.5 As a result of the change to the model of care, there will be a review of CMHT functions which may affect the allocation of professional disciplines to meet the requirements of a multi-disciplinary team.
- 4.3.6 Each sector team will be allocated an inpatient unit and it is envisaged that services will be provided across the in /out patient continuum. Movement of some staff between inpatient and outpatient settings may be anticipated i.e. staff may work in both settings.
- 4.3.7 Equalise CMHTs resources to respond to demand equitably. CMHTs will each provide a crisis resolution function, a high acuity function, manage the acute inpatient admission / discharge process (CMHTs will each manage their own inpatient beds) and provide a case management function. A consistent clinical team will provide care for the service user and their family throughout their journey.

4.4 Proposed Changes to Acute Care Provision

- 4.4.1 Re-orientate the Acute Inpatient Service (AIS) so that there are four separate units, each serving designated community teams and providing a high dependency unit
- 4.4.2 Staff may need to work across the continuum of the Adult General Services, following the patient journey. Movement of some staff between inpatient to community settings may be anticipated i.e. staff may work in both settings.
- 4.4.3 As a result of the proposed changes to acute care provision, designated positions will be reviewed to fit with the proposed new service structure.

4.5 Proposed Changes to Rehabilitation Care Provision

- 4.5.1 Hereford Centre will develop a process of review that will identify service users who require assertive outreach. It is envisaged that the Hereford Centre will have a reduced overall caseload and an appropriate multi-disciplinary staff resource.
- 4.5.2 Assertive outreach provided by the Hereford Centre is part of the continuum of care. Service users will move in and out of the assertive outreach function based on the service user's assessed need for this intensive follow-up.
- 4.5.3 It is expected that service users who do not require assertive outreach will be cared for by the newly equalised and expanded CMHTs. Some movement of staff is anticipated e.g. Hereford staff may be redeployed to community teams.
- 4.5.4 Begin an active, two-phased, reduction in the number of Seager beds from 51 to 28 beds. It is the intention that phase one will be a reduction by 11 beds and will begin as soon as possible following the consultation process. Subsequently, phase two will be a further reduction by 12 beds.
- 4.5.5 It is anticipated that there will be a further reduction in Seager Rehabilitation beds following on from phase one and two. This reduction is dependent on increased community capacity and service user need.
- 4.5.6 The remaining Seager beds will be for those service users that require hospital level care due to their high and complex needs and there will be an appropriate multi-disciplinary staff resource.
- 4.5.7 Tupuna Rehabilitation Unit will develop a process of review that will identify service users for whom community options would be viable. Any vacated Tupuna beds may be used for service users with long-term, high and complex needs.

- 4.5.8 It is envisaged that the physical location for longer term adult inpatient services currently known as Seager will be on the Hillmorton site.
- 4.5.9 As a result of the closure of Rehabilitation beds, movement of some staff from inpatient to community teams or redeployment into vacancies in inpatient units is anticipated.

4.6 *Changes Affecting Infrastructure*

- 4.6.1 SMHS documentation requirements and processes will be reviewed and changed to ensure that it supports the service user journey and that duplication is reduced.
- 4.6.2 The Healthlinks information system and the relevant Service Provision Frameworks will be modified to support revised models of care delivery that fully support the provision of seamless care.
- 4.6.3 Better ways of sharing information with the wider health sector will be explored, in particular with Primary Health Care and mental health NGOs.
- 4.6.4 The proposed changes are likely to have major implications for facilities across SMHS. This issue has been intensified in the aftermath of the Canterbury earthquakes, with several teams displaced. Appropriate accommodation for all teams will remain a priority. This is a key factor in ensuring the proposed changes have optimum impact on the quality of our service.

4.7 *Changes Affecting Service Leadership Structures*

- 4.7.1 The proposed SMHS service area structures and leadership will reflect the proposed changes to the model of care delivery to ensure that robust governance oversees the new way of working.
- 4.7.2 The current leadership representation of Maori, Consumer Advisor and Family Advisor will be retained in the new service structure and its Directorates.
- 4.7.3 Affected designated leadership positions will be reviewed to fit in the new service structure.
- 4.7.4 The following organisational structure (also see appendix 5) is proposed by the Adult Services Leadership Group:
 - 4.7.4.1 Four service areas (North Adult General Mental Health Service, South Adult General Mental Health Service, East Adult General Mental Health Service, West Adult General Mental Health Service) that each include a newly equalised CMHT with a crisis resolution function, an

inpatient unit and other SMHS Team portfolios. Each Service Area will be led by an Executive Leadership Team comprising a Clinical Director, Service Manager and Nurse Consultant.

4.7.4.2 It is proposed that an Allied Health Professional Representative is added to the Executive Leadership Team.

4.7.4.3 As well as vertical responsibilities for an inpatient ward and CMHT, each service area will have a specific portfolio e.g. Rehabilitation and Hereford; Addictions, Mothers and Babies and Eating Disorders, Anxieties, Ashburton, Rural Mental Health, Totara, Watch-house, MHL and Psychiatric Consultation, Refugee and Migrant and NGO Liaison (please note: these are examples of distribution only). It is proposed that portfolios are divided up according to the equalisation of work load and alignment of functions.

4.7.5 It is envisaged that the Adult General Services Leadership Group will continue to meet regularly to embed the new way of working and to ensure that consistency across service areas is maintained.

4.8 Other Service Implications

4.8.1 Totara House

Review the functions of Totara House (early intervention in psychosis) to ensure that the specialist input that is offered is effectively targeting those service users most in need of their expertise and that resources allocated are appropriate.

In conjunction with the Totara House Review, service delivery for CAF service users with psychosis, will be included.

It is anticipated that this review will occur in 2012. Terms of reference will be developed for the 2012 review.

4.8.2 Child, Adolescent and Family

Review the delivery of the crisis resolution function for service users of the Child, Adolescent and Family Service.

It is anticipated that this review will occur simultaneously to the Adult General Services Proposal for Change. Terms of reference will be developed for the review.

5. Impact on Staff

The aim of this proposal is to ensure that the model of care delivery is responsive to services users and their families/ whanau. SMHS acknowledges that the proposed changes may be an unsettling experience for affected staff. SMHS aim is to be transparent in its processes and timelines.

5.1 Staffing

- 5.1.1 The SMHS does not envisage any loss of SMHS staff. As we wish to retain our highly skilled staff, our overall objective is to redeploy staff within SMHS. It is not intended that redundancies will occur as a result of this proposal. SMHS staff may be required to move to other locations. There will be opportunities for changes in roles.
- 5.1.2 The proposed bed reductions across the inpatient rehabilitation service will have implications for affected staff. It is the intention that all staff will continue to work within SMHS and that there will be no loss of SMHS staff as a result of these proposals. A number of staff will be retained in the units, while others will be redeployed to other inpatient areas or have opportunities to transition to CMHTs.
- 5.1.3 The proposed changes within CMHTs and emergency response systems may change working hours, potentially for all disciplines. It is expected that for the changes to have the necessary impact on service provision, there will be changes to working hours as a result of this proposal, for example, the probability of working evening and weekend shifts.
- 5.1.4 This Proposal For Change is across the whole of the Adult General Services area. Whilst the implementation phase will be expedited, the timeframe will be dependent on projects such as the AIS rebuild (appendix 2). Any affected staff will be consulted about alternative placements for an interim period.

5.2 Impact on Professional Groups

- 5.2.1 Changes to the size and function of the teams will require a restructure of the professional leadership as well as line and service management of the teams and a revised service structure. The current leadership representation of Maori, Consumer Advisor and Family Advisor will be retained in the new service structure and Directorates.
- 5.2.2 It is envisaged that affected nurses and allied health professionals will have opportunities to transition to community roles or existing vacancies in SMHS.
- 5.2.3 Any affected non-clinical staff such as Pukenga Atawhai, secretaries and housekeepers would be redeployed to community mental health teams or equivalent roles in inpatient areas.

- 5.2.4 There will be no loss of Senior Medical Officers (SMOs) FTE as a result of this proposal. SMOs may be required to move to other locations. After the new service structure has been finalised, consultation will occur with SMOs regarding their medical team configuration.
- 5.2.5 This Proposal for Change will not significantly impact on Registered Medical Officers (RMOs) and House Officers. Training requirements will be met with runs available in adult general psychiatry and acute psychiatric medical intervention available through the newly equalised community mental health teams and high dependency units in each of the four inpatient units. It is not envisaged that any significant additional travel will occur as a result of the proposed changes.

5.3 Process for Affected Staff

Where proposed service changes affect staff the following process will be followed:

- 5.3.1 Meetings will be held with affected staff to give them the opportunity to consider the proposal, ask questions and comment on the proposed changes, the processes for potentially impacted staff and the proposed timelines.
- 5.3.2 Meetings will be held with representative unions to discuss the rationale for the proposal and to provide an opportunity for unions to ask questions and give their perspective on the proposal.
- 5.3.3 A single contact and email address will be provided so that staff and unions can direct questions and receive timely feedback.
- 5.3.4 The reduction of inpatient FTE will be accompanied by the establishment of community FTE and notification of opportunities for redeployment to other SMHS inpatient areas.
- 5.3.5 It is envisaged that designated positions will be disestablished and re-established. The newly established positions will reflect the new service structure.
- 5.3.6 The timeframe to complete redeployment/ disestablishment of positions will be dependent on other SMHS projects such as the AIS rebuild. Staff will be consulted or informed, as appropriate.
- 5.3.7 Expressions of Interest (EOI) in any of the newly established positions will be made available to potentially affected staff within a designated timeframe. Job descriptions are available on the Mental Health Division intranet (appendix 4). If the proposal goes ahead, affected staff will be given priority for positions as per CDHB practice.

- 5.3.8 Those staff not successful in securing the newly established positions, following their EOI, will be offered redeployment and will be prioritised for other SMHS positions available through vacancies at the time of the process.
- 5.3.9 If potentially affected staff do not wish to apply for the newly established positions, they can signal their interest in other positions to their Line Manager who will work with the Human Resource Advisor to ensure they are given prioritisation.
- 5.3.10 The SMHS will work with potentially affected staff and their unions as per Section 31 of the Public Service Association Allied Health, Public Health and Technical Multi Collective Agreement, 1 April 2010; Section 38 of the Mental Health and Public Health Nurses MECA, 1 April 2010; Section 37 of the National Union of Public Employees, Allied Health and Technical and Mental Health Nursing Collective Employment Agreement, 1 April 2010; Section 24 of the New Zealand Nurses Organisation, Nursing and Midwifery MECA, 1 April 2010; Sections 43 to 45 of the Association of Salaried Medical Officers, Senior Medical and Dental Officers MECA, 9 September 2010; and Section 43.4 of the Resident Doctors Association, Resident Medical Officers MECA, 29 August 2008.

5.4 Training

The Training and Development committee is undertaking a review to ensure that training is well co-ordinated and meets the needs of the SMHS staff. As services are changing and being developed there will need to be ongoing updated training and support. Appropriate and targeted training will be provided for clinical staff in line with the new initiatives and roles. No staff members will be expected to undertake new roles without receiving the necessary training and orientation.

6. Proposal For Change Consultation

Feedback from staff, unions and interested parties is required to be submitted to Sharryn Sunbeam, PA to the Divisional Executive Team, by close of business on 9 August 2011.

If you have questions you wish to ask about the Proposal For Change please contact Cate Kearney on extension 34181 or email M.H.Plan@cdhb.govt.nz

The feedback will be considered by the Divisional Executive Team (DET) that comprises the General Manager, Chief of Psychiatry, The Director of Nursing, the Allied Health Professional Leader and the Operations Manager. The DET will consult with key stakeholders (for example Maori, Service Users, Family, and NGOs) as required.

Should it be decided that the proposal is to proceed, the final proposal will be released on 7 September 2011.

7. Conclusion

The Adult General Services Proposal for Change is the result of a clinically led planning process. This proposal summarises key issues within Canterbury DHB Specialist Mental Health Services for adults and proposes significant large scale changes to the structure and functions of services. The proposed changes are required to enable us to improve our responsiveness to people that use mental health services, their families and our community.

This document is a proposal and no decision on any changes has yet been made. It is being made available to all affected employees, unions and other key stakeholders. As always, EAP (0800 327 669) is available for staff for personal support during this process.

Your support will assist in the reorientation of Adult Mental Health Services to ensure the right services are provided to the right people and their families and whanau at the right time and at the right place – which is whenever possible, in the community.

8. Timeframe

29 June 2011	<i>Proposal for Change released</i>
9.00 a.m. 30 June 9.00 a.m. 7 July 9.00 a.m. 14 July 9.00 a.m. 21 July 9.00 a.m. 28 July 9.00 a.m. 4 August	<i>Proposal for change meetings.</i> The Princess Margaret Hospital, B Wing Lounge, Seager Unit Hillmorton Hospital, Lincoln Lounge The Princess Margaret Hospital, B wing Lounge, Seager Unit Hillmorton Hospital, Lincoln Lounge The Princess Margaret Hospital, B wing Lounge, Seager Unit Hillmorton Hospital, Lincoln Lounge Meetings will be attended by at least one representative of the Adult Services Leadership Group.
9 August 2011	<i>Submissions on Proposal for Change close</i>
20 September 2011	<i>Interim Direction of Change decision released</i>
17 October 2011	<i>Submissions on Interim Direction of Change close</i>
21 November 2011	<i>Direction of Change decision released</i>
21 November 2011	<i>The change process commences</i>

Sandra Walker

General Manager

Appendix 1

Adult General Services Leadership Group

Dr Steve Duffy, Clinical Director, Acute Inpatient Service
Anne-Marie Wijnveld, Nurse Consultant, Acute Inpatient Service
Tony Lockington, Service Manager, Acute Inpatient Service
Dr Harith Swadi, Acting Clinical Director, Rehabilitation Service (until May 2011)
Dr David Stoner, Clinical Director, Rehabilitation Service (from May 2011)
Karen Harrington, Acting Nurse Consultant, Rehabilitation Service
Wendy Lowison, Nurse Consultant, Rehabilitation Service
Kathy O'Neill, Service Manager, Rehabilitation Service
Dr Peri Renison, Clinical Director, Adult Community Service
Craig Cowie, Nurse Consultant, Adult Community Service
Deborah Selwood, Service Manager, Adult Community Service
Ron Chambers, Professional Advisor, Psychology

Appendix 2

Glossary of Terms

AIS	Acute Inpatient Service
AIS rebuild	Reconfiguration of Te Awakura Adult inpatient unit from three inpatient areas to four inpatient areas each with a high dependency unit
CMHT	Community Mental Health Team
DET	Divisional Executive Team, the leadership group for SMHS
Disestablishment	Position no longer exists. Staff will need to apply for a new role or similar role in a similar setting.
Redeployment	staff are placed in a different unit where the job content is not significantly different from their current role.
Relocation	Movement of physical environment with no change to role
SMHS	Specialist Mental Health Services

Appendix 3

Crisis Resolution Function

Definition

In a crisis resolution context, a crisis is defined as the breakdown of an individual's normal coping mechanisms. Crisis resolution services respond to crises associated with severe mental illness (Rosen, 1997).

Crisis resolution is an alternative to inpatient hospital care for service users with serious mental illness offering flexible home based care, 24 hours a day, seven days a week. Crisis resolution is a process of working through the crisis to the point of resolution. The main aim is to provide home assessment and treatment to prevent hospital admission (Sainsbury Centre for Mental Health, 2001)

Core Characteristics

- Interventions are intensive and short term, often just one to two weeks
- Rapid response – in urban areas staff are available within the hour
- Frequent daily visits to each client and their social network is required
- Social issues are addressed as part of the overall care plan
- Support and education is available to family and carers
- Involvement continues until the crisis is resolved
- Services act as gatekeepers to acute inpatient care
- Crisis resolution can also support people to be discharged from hospital earlier, with increased support available in the home

Comparison between Crisis Resolution and Assertive Outreach;

	Crisis Resolution	Assertive Outreach
Length of involvement	Short term usually 2-3 weeks	Longer term
Service User	May have no previous contact with psychiatric services	Established psychiatric history
Referrals	From GPs, ED, and self	Usually referral is from a secondary service team
Hours of Operation	24 hours	Usually more limited
Service Delivery	Rapid response – within one hour	Longer response time, especially for clients not previously known to the service.
Other	Acts as gatekeepers to inpatient beds	No gate keeping role

Functions to be covered in Service Provision Framework

Service aims objectives, rationale and goals

Service user group

Referral process – acceptance and exclusion criteria

Criteria for hospitalisation

Assessment guidelines

Recovery plan and clinical review forums
Discharge from inpatient unit
Discharge from crisis resolution services

Operational Procedures

Function description
Staff roles and allocations
Shift system/ out of hours medical cover/on call arrangements
Personal safety and communication
Team management
Organisational structure
Interagency working guidelines

References

The Sainsbury Centre for Mental Health 2001. Mental Health Topics; Crisis Resolution
Rosen, A (1997) Crisis Management in the Community. *Medical Journal of Australia*, 167 (11-12)
Rethink (2009). Crisis Resolution

Appendix 4

Job Descriptions

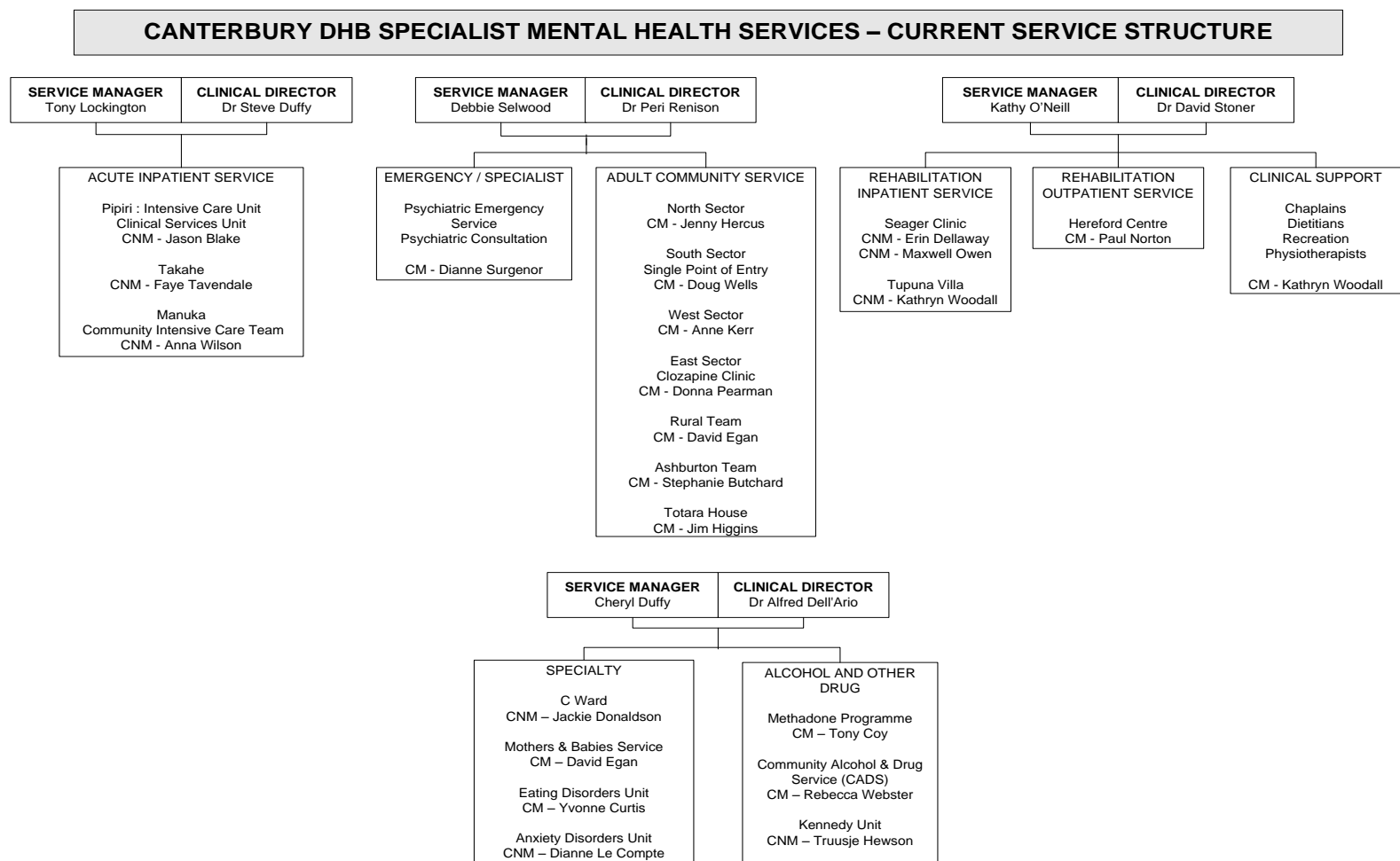
Nursing Job descriptions can be located on the Mental Health Division Intranet:

<http://intraweb.cdhb.local/mh%2Dnursing/job-description.htm>

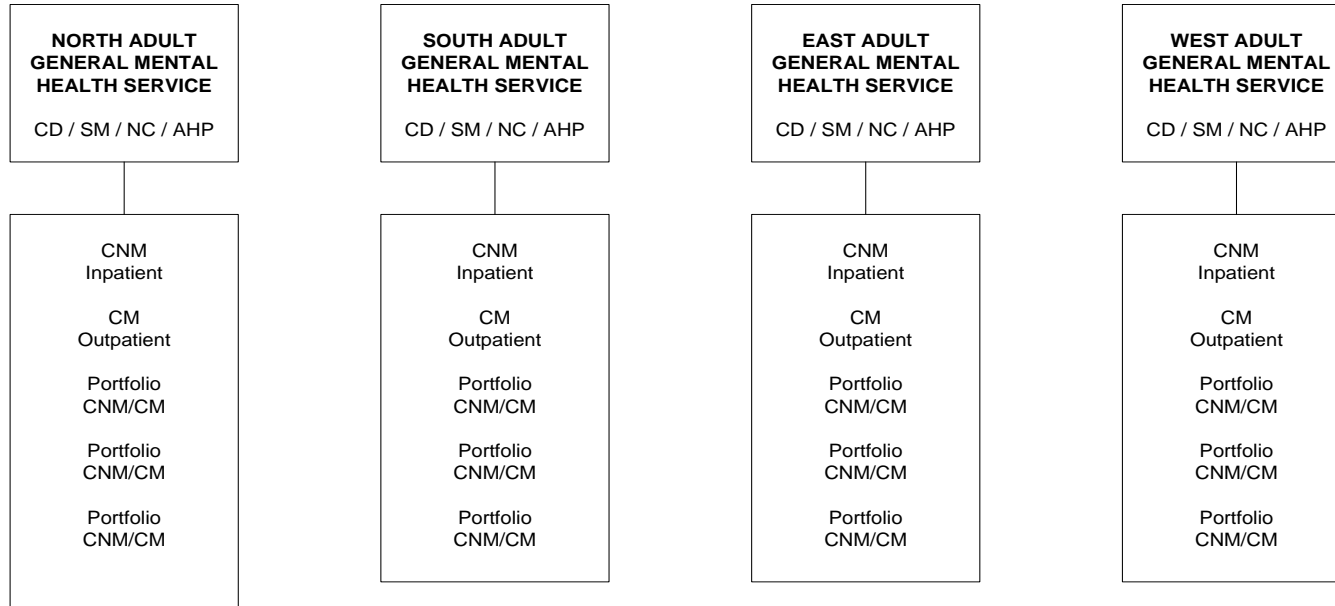
Allied Health Job Descriptions can be located on the Mental Health Division Intranet:

<http://intranet/division/mh/ah/default.aspx>

Appendix 5 Current and Proposed Leadership Structures



**CANTERBURY DHB SPECIALIST MENTAL HEALTH SERVICES –
PROPOSED ADULT GENERAL SERVICE STRUCTURE**



Key
 CD - Clinical Director
 SM - Service Manager
 NC - Nurse Consultant
 AHP - Allied Health Professional Representative
 CNM - Charge Nurse Manager
 CM - Clinical Manager
 Portfolios – examples of distribution only