

Canterbury

District Health Board

Te Poari Hauora o Waitaha

Interim Direction of Change

**Adult General Mental Health
Services**

26 January 2012

Specialist Mental Health Services

From the Divisional Leadership Team

The Interim Direction of Change document is the result of a clinically led, consumer, family Maori and NGO inclusive, strategic planning process. We thank everyone who provided feedback to the proposal for change. All verbal and written feedback has been carefully considered and we are pleased now to release this document. We especially thank the adult leadership team for the tremendous amount of collaborative work that they have undertaken to complete this.

The Divisional Leadership Team is pleased to now endorse the release of the Interim Direction of Change for further consultation.

This document is an interim Direction of change and your feedback is welcome. Consultation is ongoing and as yet no final decisions have been made.

We encourage debate, participation in the forums and look forward to your feedback. Feedback from staff, unions and interested parties is required to be submitted to Sharryn Sunbeam, Sharryn.sunbeam@cdhb.health.nz by close of business on 9 March 2012.

26 January 2012	Interim Direction of Change released
	Interim Direction of Change forums:
3 February 2012	2.00 – 3.00pm, Lincoln Lounge, Hillmorton
9 February 2012	9.00 – 10.00am, Fountain Room, Hillmorton
17 February 2012	1.00 – 2.00pm, Fountain Room, Hillmorton
23 February 2012	10.00- 11.00am Fountain Room, Hillmorton
Consumer forum	TBA
Family & whanau forum	TBA
Provider Forum	TBA
09 March 2012	Submissions close on Interim Direction of Change
23 April 2012	Final Direction of Change decision released
23 April 2012	Change Process commences

We look forward to working with you during this stage of the process.

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1. INTRODUCTION

The release of this document signals the next stage in the journey towards a community orientated, recovery focused adult mental health system for Canterbury which is integrated, responsive, flexible, consumer centred and family-whanau inclusive.

Since the publication of the Proposal for Change in June 2011, clinically-led planning, discussion and consultation processes have been underway with a view to develop a plan and formulating specific strategic directions for how the proposals may become a reality. Consumer, Family and Maori advisors have been involved in this process. The Proposal for Change document elicited a large number of submissions which have all been carefully considered and where possible suggestions have been included in this document.

The process is a significant undertaking and this document marks a major milestone in what has been and will continue to be a gradual, measured and challenging process.

This document aims to outline the first building blocks necessary for a new, reconfigured system of mental health care and signal how the separate components of the current adult services may be enhanced, developed, altered and aligned to become integrated functions of a seamless and more efficient mental health system.

The scale and scope of the proposed changes to service delivery are broad-ranging and complex and this document is unable to provide all the detail on what is a long-term strategic process. The main purposes of this document are to outline the key principles of service design and how the specific proposals would be realised.

SMHS recognises that we are operating in a fiscally restrained environment and the proposed changes must be supported within our existing resources. Your submissions will enable us to prioritise implementation of the different initiatives and prioritise resources accordingly.

2. KEY PRINCIPLES

The SMHS Framework for Mental Health and Wellbeing (2010-2015) clearly states some foundation principles for a high quality service. These are:

- Providing a Service which is Consumer centred and Family-Whanau Inclusive
- Providing a service which is Recovery Focused
- Providing a service which is Responsive and Flexible

These core elements provide the basis for a shared vision for the future of Specialist Mental Health Services in Canterbury as outlined in the adult plan and the proposal for change. In order to focus and further advance the process of change, it is necessary to build on these core elements with more specific principles upon which practices and service delivery may be based across the entire continuum of care.

3. INTERIM PLANNING

Making the first steps towards implementing these proposals and a new service model needs considerable strategic planning. A transfer of resources to SMHS community functions to facilitate service development and enable mental health services to provide the necessary levels of community care is required.

Some changes may require 'bridging' support, in which case SMHS would seek funding or other resources and support from Canterbury DHB to allow implementation of key parts of the service plan. This may include temporarily increasing levels of community based input and support, to ensure the needs of those consumers most directly affected by the changes continue to be met.

Part of this process will include examining current practices within teams to preserve, promote and enhance those which are already aligned to the proposed new service model and using these as a template for further and wider development.

4. THE OVERARCHING ROLE OF THE COMMUNITY MENTAL HEALTH FUNCTION

NB: In this and the following section (sections 4 and 5) the wording in bold at the beginning of each section is the wording in the Proposal for change. If there is no further comment, this now becomes the interim direction of change. If there is comment, the new comment is the proposed interim direction for change.

In Section 4, the implications for staff are boxed at the end of each section, linked by the relevant sub-section numbering.

SMHS aims to remove traditional boundaries between providers in order to achieve the best possible health outcomes for the consumer and their family / whanau. A major factor in achieving this under the proposed service model will be to develop additional specialist functions within each team and place the locus of care in the community. These functions include:

- Access to Services
- Routine Case Management
- Crisis Resolution Functions
- Acute Inpatient Function
- Extended Treatment Function

4.1 Access to Adult General Services

Our aim is to have a system which supports and facilitates fast, efficient and thorough assessments when and where they are most needed. This will be followed by quick and easy access to appropriate services when necessary.

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.

SPOE will continue to function as telephone triage for planned referrals and booking assessments. It is a first point of contact for the public and will offer a caller an urgent assessment via the crisis resolution function if required. A 'duty' person from each CMHT will provide additional back-up for SPOE.

After hours, the SPOE triage function and emergency call response will continue through the crisis resolution function.

The SPOE function will not be undertaking brief assessments for self presentations. It is envisaged that the CMHTs (via crisis resolution) will include completing a brief assessment (similar to that known as CAPA¹) and offering advice as a part of their role.

4.1.2 SPOE will be further developed and expanded 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.

The Single Point of Entry (SPOE) function will be developed to provide enhanced telephone triage, and support to primary care and the wider health system via consultation/liaison and advice.

Referrals including out of region referrals and emergency calls will come through SPOE. SPOE will coordinate crisis resolution responses including a brief assessment option if required.

Anyone may contact SPOE for advice.

4.1 Implications for staff:

SPOE staff will continue to be involved in service development initiatives in line with the direction of change once confirmed. Modified systems to enable the SPOE functions may be developed. A system to enable CMHT duty workers to provide back up to SPOE will be developed. No staff FTE changes are part of this process.

¹ See Glossary for explanation of CAPA

4.2 Proposed Change to Crisis Resolution and Consultation Provision

4.2.1 The current PES function will become part of an integrated crisis resolution function within CMHTs.

Crisis resolution is an alternative to inpatient hospital treatment. It has a gate-keeping role to inpatient care, facilitates alternatives to inpatient care and also supports discharge from hospital through the provision of increased support in the home or community. It is a process of working with the consumer and their family through the crisis to the point of resolution.

The crisis resolution function will replace the existing Psychiatric Emergency Service (PES) and community intensive care (CIC) function. Consumers requiring crisis resolution will be assigned a case manager where appropriate (if new to service). When the crisis resolution function is required, case managers will remain engaged with the consumer.

Case managers will be expected to fulfil a general crisis resolution role for those on their case load. For more complex cases or crises, they will engage the team's crisis resolution functions within and after hours. All consumers from across SMHS will be able to access crisis resolution services as required.

Crisis Resolution is usually brief and intensive, continuing until the crisis is resolved.

This may include multiple daily visits to consumers and their supports with social issues being addressed as part of overall treatment goals.

It is intended that SMHS will link with NGO services to enable Community Support Workers (CSWs) to be involved as appropriate.

Other emergency responses via the Emergency Dept and Police Watch House Service will continue as currently.

Under the new service model, crisis resolution will be a 7 day / 24 hr mobile rapid response function within teams. Those accessing crisis resolution may not necessarily have had contact with mental health services previously. It is envisaged that the crisis resolution function will be embedded in each of the CMHTs from approximately 0800 – 2300 daily. It is anticipated that on average four staff per team per shift would be engaged in the crisis resolution function. However there will be ongoing mapping of demand for crisis resolution services and shift start and end times may flex and / or change to meet demand. From approximately 2300 – 0800 the crisis resolution function will be pooled across the four teams.

4.2.2 The primary model of service delivery for the crisis resolution function will be mobile teams that visit the service user in the most appropriate

setting 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.

Under the new service model, Crisis Resolution will be a 7 day / 24 hr mobile rapid response function based within teams between approximately 0800 – 2300. After 2300, the crisis resolution staff will be based together at a central location. It is likely that there will be two crisis resolution staff members (in addition to the registrar) on duty overnight.

A roster for the crisis resolution function will be developed. This will be reviewed regularly as a result of demand mapping to ensure service capacity best meets service demand.

4.2.4. Hours of work will reflect SMHS intention to provide a flexible extended service.

Under the proposed new service model, the crisis resolution function will be a 24 hour/7 day a week function.

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.

Staff may be required to perform any functions of the team. Orientation and an ongoing training and development programme will be provided to all CMHT staff to support this and build capability and capacity within the teams.

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.

The current Mental Health Liaison (MHL) and the Psychiatric Consultation Service (PCS) teams will be combined and be known as the Mental Health Consult and Liaison team. The mental health consult and liaison team will hand over to the relevant CMHT, services users requiring longer term interventions.

Mental Health Consult and Liaison (MHCL) Function

The MHCL function will be responsible for the mental health needs of patients admitted to Christchurch hospital. Psychiatric consultation and liaison will include:

- In-reach, brief interventions to inpatients of Christchurch Hospital

- Provision of psychiatric, psychological and nursing assessment and management advice
- Mental health nurses will provide consultation and liaison support to inpatient nurses to develop treatment plans that address mental health needs
- Mental health screening, appropriate assessment, consult and liaison function within the emergency department.
- Where ongoing involvement with the SMHS is indicated, the relevant crisis resolution team will be engaged.
- Assessment of patients medically admitted post overdose

If a current SMHS consumer is admitted to Christchurch Hospital, the case manager/CMHT will continue to be involved in treatment and discharge planning and processes.

4.2.7 Review provision of the crisis resolution function for those under 18 years.

CAF services will undertake assessments of all new crisis resolution presentations of those under 18 years of age between 0800 and 1700. CAF services will be expected to review all after hours CAF presentations the next working day. A process of communication will be developed for after hours' presentations to ensure an effective transition.

4.2 Implications for staff:

4.2.1 Crisis resolution

The current PES and CIC teams will cease to exist. Replacing these will be a crisis resolution function embedded in each team. It is envisaged that the crisis resolution function will be based in each of the CMHTs from approximately 0800 – 2300 daily. It is anticipated that on average four staff per team per shift would be engaged in the crisis resolution function. Ongoing mapping of demand for crisis resolution services and shift start and end times may flex and / or change to meet demand. From approximately 2300 – 0800 the crisis resolution function will be pooled across the four teams and operate from a central location.

4.2.2 Resources

Case management staff numbers within the CMHTs will be increased by reallocating available Seager Clinic and Hereford Centre resources.

4.2.5 Staff rotations

Ongoing training will be provided to all CMHT staff to build capability and capacity for staff to rotate through various functions within the teams.

4.2.6 Combine MHL and PCS

The current MHL and PCS will cease to exist. Replacing these will be a single Mental Health Consult and Liaison team to perform multiple functions based at Christchurch hospital. The discipline mix and hours of work will be reviewed to best meet consumer need. It is envisaged additional nursing FTE will be required.

4.2.7 CAF Crisis Resolution

CAF services will develop their crisis resolution processes separate to this proposal. A process to ensure effective transition between adult and CAF services for after hours presentations will be developed.

4.3 Proposed Changes to Community Mental Health Care Provision

The proposed service model is envisaged to have a single integrated MDT functioning across outpatient and inpatient settings working from a single treatment plan to ensure flow of information and continuity of care. For this to happen, both community and inpatient functions will require a discipline mix which enables the specific expertise of each discipline to be appropriately utilised when and where it is needed most. The Specific principles of the Model of care include:

- Treatment is provided or facilitated by a single team, regardless of the setting.
- Each CMHT will manage their inpatient beds
- There is one treatment plan
- Community focus is maintained regardless of care setting
- Each consumer has an identified community case manager and MDT continuity across care settings
- Every health professional is clinically responsible within their scope of practice.
- Every health professional works within the MDT framework.
- There are handovers rather than referrals within the system
- There are no reassessments but regular reviews as necessary.
- Goals are always focused on achieving most socially inclusive, least restrictive treatment and discharge
- Communication and documentation processes are effectively streamlined across settings and disciplines
- There is a flexible approach to service delivery in terms of hours of work, mobility of teams and care environment matched to individual consumer need
- There are FTE levels and cover arrangements within and across settings
- The personal resourcefulness of consumers and their families-whanau is valued and incorporated into recovery planning and service delivery.

The case management role will be carried out by community mental health nurses, social workers, occupational therapists and clinical

psychologists. Case loads will need to be carefully managed and planned to ensure the protection of time for profession specific skills and roles.

It is acknowledged that each team will undertake some long term case management. The relationship between specialist mental health services and NGOs is pivotal in ensuring collaboration to maximise positive outcomes for consumers requiring extended periods of treatment and support.

Allied Health Professionals (AHP) have a range of skills and expertise which sit equally well in community and inpatient settings, with specific aspects of their role suited to each. Current AIS inpatient allied health professional staff will be relocated and assigned to CMHTs. Reflecting the changes and subject to review, the occupational therapy, social work and psychology resource for each inpatient team will be provided by direct allocation from each CMHT. Some of the roles currently performed by inpatient AHPs will be undertaken by the CMHT. Case loads of those employed in dual roles will be structured to ensure inpatient coverage is not compromised. Active caseload management over the service continuum will be required. Similarly, balancing overall service capacity demands will require proactive management processes.

Dietitians and physiotherapists will continue as at present to manage demand across the inpatient/community continuum.

It is planned that one fulltime Pukenga Atawhai will be allocated to each CMHT to work across the community and inpatient continuum. This will be drawn from the current resource of PES, AIS, Rehabilitation and the four main Sector Bases. At this stage, other Pukenga Atawhai resource allocation (e.g. Hereford Centre, Totara, Rural, CADS and CMP) will remain unchanged. However, in consultation with Te Korowai Atawhai, staff may need to be redeployed to match the new service configuration.

4.3.1. Increase staff numbers within CMHTs

Case management (assessment, short term follow-up, extended case management and including working alongside crisis resolution) will therefore fulfil several key functions regardless of setting. Case managers will be fully mobile and will work within the multidisciplinary structure enabling them to work in a dynamic, responsive and flexible fashion across community and inpatient settings.

Case management staff numbers within the CMHTs will be increased by reallocating available Seager Clinic and Hereford Centre resources.

4.3.2. Expand the working hours of the multi-disciplinary CMHTs to become seven day a week extended hours' service.

Routine case management and extended treatment functions may involve rostering changes and increased flexibility of work hours for CMHT staff. This may involve some AHP staff working weekend days and may have implications for current community nurse weekend rosters.

It is envisaged that some evening clinics could be investigated to provide a more flexible option for consumers and their families.

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.

The functions as listed previously will be provided by an MDT and the appropriate discipline mix will remain under review with each vacancy to ensure the service is best able to meet the consumer needs.

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.

Current AIS inpatient allied health professional staff will be relocated and assigned to CMHTs. The CMHTs will develop systems to ensure regular and effective social work, occupational therapy and psychology in-reach services are provided to the inpatient services.

Under the proposed new service model, psychiatrist time will be split across settings with a registrar per community function and a registrar and house surgeon for each acute inpatient ward. Various options are currently being considered on how these objectives may be achieved to maximise continuity, efficiency and cover. However, each team will have it's own group of psychiatrists who work co-operatively together and cover each other on leave.

Inpatient allocation of beds includes both those from an acute inpatient ward and a yet to be determined number of sub-acute / rehabilitation beds.

4.3.7 Equalise and expand 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.

Each CMHT will include the following functions

- Crisis Resolution function
- Inpatient in-reach function
- Assessment and Case Management
- Extended treatment function

4.3 Implications for Staff

4.3.1 Increase in staff in CMHT

Case management staff numbers within the CMHTs will be increased by reallocating available Seager Clinic and Hereford Centre resources.

4.3.2 Expanded working hours of CMHT

Routine case management and extended treatment functions may involve rostering changes and increased flexibility of work hours for CMHT staff. This may involve some AHP staff working weekend days and may have implications for current community nurse weekend rosters.

Evening clinics to provide a more flexible option will be considered.

4.3.6 Staff involved in inpatient and outpatient settings

Current AIS inpatient allied health staff will be relocated to and work within a CMHT, distributing the FTE across the teams as equitably as possible. Training, orientation and mentoring will be provided as needed to support any up skilling that may be required. CMHTs will develop systems to ensure effective AHP in-reach services to AIS are maintained.

Psychiatrists may be required to work across inpatient and outpatient settings.

4.4 Proposed Changes to Acute Care Provision

Inpatient admission and discharge will be managed by the crisis resolution function of the MDT. Each team (Inpatient and community functions) will be led by a single MDT, with specific disciplines, in some cases 'working across' inpatient and community as previously stated with specific time dedicated to each where necessary. Where appropriate, a consumer (not already known to the services) being admitted for inpatient treatment will be allocated a community case manager. The team will be fully involved during any inpatient admission of a consumer on their case load. They will also be involved in discharge planning from the point of admission and will attend inpatient meetings and discussions.

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.

The inpatient rebuild, outlined in previous documents will support the new model of care. The rebuild will have implications for staffing and working practices in Te Awakura. Exact staffing levels are yet to be determined.

Designated senior nurse positions currently in AIS, Seager and Tupuna will be reviewed to ensure they are most appropriate and sited where most needed. It is envisaged that some roles will include evening and weekend leadership and will work across all adult general inpatient beds i.e. current AIS, Seager and Tupuna.

Hospital aide and housekeeper roles will be reviewed, possibly with a view to their being used across all wards. Existing FTE in these roles will be maintained.

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.

Current AIS inpatient allied health professional staff will be relocated and assigned to CMHTs. The CMHTs will develop systems to ensure regular and effective social work, occupational therapy and psychology in-reach services are provided to the inpatient services.

Under the proposed new service model, psychiatrist time will be split across settings with a registrar per community function and a registrar and house surgeon for each acute inpatient ward. Various options are currently being considered on how these objectives may be achieved to maximise continuity, efficiency and cover. However, each team will have it's own group of psychiatrists who work co-operatively together and cover each other on leave.

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.

It is envisaged that some designated senior nurse positions may be disestablished and new designated positions established to meet the requirements of consumers and the service. It is envisaged that there will be no overall reduction in the total number of senior nursing designated positions.

AHP designated positions currently flex to respond to changes in service needs and no current designated positions for allied health staff will be affected by this process.

The Inpatient Wellbeing Programme:

As the capacity of purposeful peer support² services has grown along with awareness of its benefits, Canterbury consumers have increasingly fed back to SMHS a desire for more access to this service. Under the proposed new service model, we would anticipate that the wellbeing programme will be peer supported, with relevant involvement from clinicians and NGO providers. The Wellbeing Programme will reflect the needs of the consumers and their families and places strong emphasis on collaboration and inclusiveness. Peer support has enormous potential to profoundly influence a recovery approach in services and as such is congruent with SMHS framework principles.

The Inpatient Wellbeing Programme will be the subject of a separate project.

4.4 Implications for Staff

4.4.1 Reorient AIS into four wards

Exact staffing levels are yet to be determined. Staffing for the four wards will be flexible allowing for demand and acuity of the consumer group. At capacity, for each of the four 16 bedded wards (each with their own 3 bed 'High Care' area) it is likely to be:

- 1 Charge Nurse Manager
- 1 CNS (with a 0.5 patient caseload)
- 5 Registered Nurses (morning shift).
- 5 Registered Nurses (afternoon shift)
- 2 night shift RNs per ward and two RNs who will go to the wards with the highest acuity as need dictates

Designated senior nurse positions in AIS, Seager and Tupuna will be reviewed to ensure they are most appropriate and sited where most needed. Some of these roles may change to include evening and weekend leadership.

Proposed new senior nurse positions.

A Daytime Adult service Duty Nurse Manager will work from 0700 – 1600, Monday to Friday. The role of this Duty Nurse Manager includes Facility management, emergency and disaster management and 'in the moment' staffing management for adult inpatient beds i.e. current AIS, Seager and Tupuna.

Afternoons and weekend day shift Clinical Nurse Co-ordinators will cover seven days per week. The role of clinical nurse co-ordinators will include 'in the moment' clinical, staffing and bed management for adult inpatient beds i.e. AIS, Seager and Tupuna. These positions will report to Daytime Adult service Duty Nurse Manager but on a day to day basis will report to the SMHS Duty Nurse Manager

² Please see Appendix for further information on Peer Support

Hospital aide and housekeeper roles will be reviewed, possibly with a view to their being used across all wards. Existing FTE in these roles will be maintained.

4.4.2 Staff involved in inpatient and outpatient settings

Current AIS inpatient allied health staff will be relocated to and work within a CMHT, distributing the FTE across the teams as equitably as possible. Training, orientation and mentoring will be provided as needed to support any up skilling that may be required. CMHTs will develop systems to ensure effective AHP in-reach services to AIS are maintained.

4.4.3 Designated positions

Some designated senior nurse positions will be disestablished. New positions will be established as needed to meet the requirements of consumers and the service. It is envisaged that there will be no reduction in the total number of senior designated nurse positions.

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 users' assessed need for this intensive follow-up.

Under the proposed new service model, the existing Hereford Centre team will be replaced by a dedicated Assertive Outreach Team, offering intensive support to people with serious mental health problems complicated by multiple and complex needs.

It is anticipated that this team will work with approximately 100 consumers and will have the capacity to see consumers daily when necessary. The assertive outreach team will be required to undertake a flexible whole of team approach and have a range of skills and outreach options available. They will collaborate creatively with consumers, their family or whanau, carers and significant others developing trusting working relationships aiming for consumer engagement with the wider mental health services.

The team will function as a 7 Days per week service (0830-1700). The roster will be organised to meet service delivery needs. The assertive outreach team will work closely with NGO service providers. The make

up of the team will reflect the needs of the newly identified consumer group.

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.

As a result of reduced demand in recent months, Seager inpatient beds will be reduced by 27 in stage one. Following the 27 bed reduction, the remaining ward or wards will continue to be staffed appropriately.

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.

This section of the proposal will be re evaluated after section 4.5.4 above is completed.

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.

The remaining sub-acute / rehabilitation beds will be developed to meet the needs of those individuals with the most complex psychiatric presentations often requiring use of the Mental Health Act. The model of community based case management across the inpatient-outpatient continuum will apply in the sub-acute / rehabilitation functions as in the acute inpatient function.

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.

This will be dependent on the development of a master facilities plan for 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.

Resources available from reduced inpatient beds will be devolved to CMHT FTE.

4.5 Implications for Staff

4.5.3 Movement of staff from Hereford to CMHT

With the Hereford Centre changing to an assertive outreach team, some staff will be required to also transition to CMHTs. Details of this will be identified as the service transition evolves.

4.5.9 Reduction in Seager Clinic beds

Resources available from reduced inpatient beds will be devolved to CMHT FTE.

Rehabilitation psychiatrists may be required to work in CMHTs or acute inpatient settings.

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.

The Healthlinks system will be modified to enable one treatment plan.

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.

The SMHS will work with the CDHB Electronic Records Management group to seek a resolution of this.

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.

The proposed model, in emphasising the centrality of consumer choice, expects that service delivery will be predominantly in people's homes and the wider community. Reflecting this, an outreach clinic model is

proposed. Designated community components of services (SPOE, four CMH teams including crisis resolution functions and Rural ACS) will be clustered on the Hillmorton campus as a hub to support community based treatment approaches which emphasise mobile service delivery and community integration through the use of satellite community shared (with other health, mental health and community service providers) facilities. Consumers who choose to be seen in a hub setting will have that choice.

It is proposed that the Fergusson Clinic building on the Hillmorton campus be developed as a base for the community services. East and West will relocate to the base in Fergusson. Their former sites are likely to be used as facilities for outreach clinics.

The proposed emphasis on mobile service delivery options will require an increased vehicle fleet resource, organised in a manner which provides reliable, predictable and sustainable access at all times.

Mobile service delivery will also be supported by incorporating mobile IT system technology.

4.6 Implications for Staff

4.6.4 Facilities and Model of Care

The facilities on the Hillmorton site will be used as an administrative base with much of the clinical activity being conducted within various community settings. This revised model of care will require more community home visits and more outreach clinics. Systems, community based facilities, access to vehicles and staff training to support this model of care will be developed.

4.7 Changes Affecting Service Leadership Structure

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.

Affected designated leadership positions, inclusive of service level leadership positions will be reviewed to fit in the new service structure.

4.7.4. The following organisational structure 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 may 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.

There will be four general adult services, each with a continuum of Crisis resolution, inpatient, community and rehabilitation functions and a single leadership team. Each executive leadership team will include a Service Manager, Nurse Consultant, Clinical Director and an Allied Health Professional Consultant.

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

The role of Allied Health Professional Consultant will be developed in consultation with the Allied Health Professional leader, professional advisors and the SMHS Divisional leadership team and will be congruous with the planned CDHB allied health structure.

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 Disorders, 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.

Further work and consultation related to portfolio development will be undertaken prior to decisions being made.

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.

An appropriate and collaborative governance and leadership structure will be developed.

4.7 Implications for Staff

4.7.4.1 Organisational Structure

Affected staff have been fully engaged in the ongoing development of this document. A further process of consultation with Service Managers, Clinical Directors and Nurse Consultants to effect the changed leadership structure will begin once the Direction of change is confirmed.

4.7.4.2 Allied Health Professional representative

An Allied Health Professional Consultant will be recruited into the Leadership teams following confirmation of the Direction of Change.

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.

It is anticipated that the review of Totara will be held in 2013.

It is proposed that current Totara House functions and possibly the proposed assertive out-reach team will be accommodated in community settings. Facilities used for these functions could be available to Hillmorton campus based teams as satellite facilities.

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.

CAF services will undertake assessments of all new crisis resolution presentations of those under 18 years of age between 0800 and 1700. CAF services will be expected to review all after hours CAF presentations the next working day. A process of communication will be developed for after hours' presentations to ensure an effective transition.

4.8.3 Alcohol and Other Drug (AOD) Services

It is expected that there will be direct internal SMHS and external pathways to access AOD services, consistent with the CDHB endorsed AOD project. Some consumers will be engaged with adult general services with collaboration and consultation from AOD. All clinical staff will be expected to engage with assessment planning and treatment of consumers with co-existing problems.

4.8.4 Interface with NGOs

For key functions of the proposed new service model to bring about positive outcomes for consumers and their families, it is essential that the relationship between SMHS and NGO providers is strong and based on a culture of mutual support and respect. Interfaces between SMHS and NGOs will need to be seamless with effective communication processes, building on existing strengths and facilitating smooth transitions. It is the intention that many of the proposals outlined in this document will help achieve this, particularly those which promote responsive and flexible working practices, improve access to services and promote consistent and continuous community based case management across settings.

Mutual support may be achieved through:

- Joint training initiatives.
- Targeted support for key areas of concern, e.g. consumers in NGO residential services with co-morbid alcohol and drug issues.
- Increased case manager involvement and rapid response during transitions.
- Utilising crisis resolution as CIC has been effectively used in the past.
- Appropriate use of 'Clinical' language and 'Recovery' language.
- Mutually agreed single treatment plan incorporating both NGO and SMHS priorities

4.8 Implications for Staff

4.8.1 Totara House

Totara House review will be delayed until 2013. Staff will be engaged in the process of developing a terms of reference and participating in this review.

4.8.2 CAF Crisis Resolution services

CAF services will develop their crisis resolution service and systems for those under 18 years of age, between 0800 and 1700.

5. IMPACT ON STAFF

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 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. Any affected staff will be consulted about alternative placements for an interim period.

The Following 4.1 to 4.8 is a Summary of Implications for Staff from Section 4

4.1

SPOE

SPOE staff will continue to be involved in service development initiatives in line with the direction of change once confirmed. Modified systems to enable the SPOE functions may be developed. A system to enable CMHT duty workers to provide back up to SPOE will be developed. No staff FTE changes are part of this process.

4.2

Crisis resolution

The current PES and CIC teams will cease to exist. Replacing these will be a crisis resolution function embedded in each team. It is envisaged that the crisis resolution function will be based in each of the CMHTs from approximately 0800 – 2300 daily. It is anticipated that on average four staff per team per shift would be engaged in the

crisis resolution function. Ongoing mapping of demand for crisis resolution services and shift start and end times may flex and / or change to meet demand. From approximately 2300 – 0800 the crisis resolution function will be pooled across the four teams and operate from a central location.

Resources

Case management staff numbers within the CMHTs will be increased by reallocating available Seager Clinic and Hereford Centre resource.

Staff rotations

Ongoing training will be provided to all CMHT staff to build capability and capacity for staff to rotate through various functions within the teams.

Combine MHL and PCS

The current MHL and PCS will cease to exist. Replacing these will be a single Mental Health Consult and Liaison team to perform multiple functions based at Christchurch hospital. The discipline mix and hours of work will be reviewed to best meet consumer need. It is envisaged additional nursing FTE will be required.

CAF Crisis Resolution

CAF services will develop their crisis resolution processes separate to this proposal. A process to ensure effective transition between adult and CAF services for after hours presentations will be developed.

4.3

Increase in staff in CMHT

Case management staff numbers within the CMHTs will be increased by reallocating available Seager Clinic and Hereford Centre resource.

Expanded working hours of CMHT

The roster previously known as Community Mental Health nurses PDN roster will cease, but the crisis resolution function will provide services seven days per week, 24 hours per day.

Evening clinics to provide a more flexible option will be considered.

Staff involved in inpatient and outpatient settings

Current AIS inpatient allied health staff will be relocated to and work within a CMHT, distributing the FTE across the teams as equitably as possible. Training, orientation and mentoring will be provided as needed to support any up skilling that may be required. CMHTs will develop systems to ensure effective AHP in-reach services to AIS are maintained.

4.4

Reorient AIS into four wards

Exact staffing levels are yet to be determined. Staffing for the four wards will be flexible allowing for demand and acuity of the consumer group. At capacity, for each

of the four 16 bedded wards (each with their own 3 bed 'High Care' area) it is likely to be:

- 1 Charge Nurse Manager
- 1 CNS (with a 0.5 patient caseload)
- 5 Registered Nurses (morning shift).
- 5 Registered Nurses (afternoon shift)
- 2 night shift RNs per ward and two RNs who will go to the wards with the highest acuity as need dictates

Designated senior nurse positions in AIS, Seager and Tupuna will be reviewed to ensure they are most appropriate and sited where most needed. Some of these roles may change to include evening and weekend leadership.

Proposed new senior nurse positions.

A Daytime Adult service Duty Nurse Manager will work from 0700 – 1600, Monday to Friday. The role of this Duty Nurse Manager includes Facility management, emergency and disaster management and 'in the moment' staffing management for adult inpatient beds i.e current AIS, Seager and Tupuna.

Afternoons and weekend day shift Clinical Nurse Co-ordinators will cover seven days per week. The role of clinical nurse co-ordinators will include 'in the moment' clinical, staffing and bed management for adult inpatient beds i.e. AIS, Seager and Tupuna. These positions will report to Daytime Adult service Duty Nurse Manager but on a day to day basis will report to the SMHS Duty Nurse Manager

Hospital Aide and housekeeper roles will be reviewed, possibly with a view to their being used across all wards. Existing FTE in these roles will be maintained.

Staff involved in inpatient and outpatient settings

Current AIS inpatient allied health staff will be relocated to and work within a CMHT, distributing the FTE across the teams as equitably as possible. Training, orientation and mentoring will be provided as needed to support any up skilling that may be required. CMHTs will develop systems to ensure effective AHP in-reach services to AIS are maintained.

Designated positions

Some designated senior nurse positions will be disestablished. New positions will be established as needed to meet the requirements of consumers and the service. It is envisaged that there will be no reduction in the total number of designated senior nurse positions.

4.5

Movement of staff from Hereford to CMHT

With the Hereford Centre changing to an assertive outreach team, some staff will be required to also transition to CMHTs. Details of this will be identified as the service transition evolves.

Reduction in Seager Clinic beds

Resources available from reduced inpatient beds will be devolved to CMHT FTE.

4.6

Facilities and Model of Care

The facilities on the Hillmorton site will be used as an administrative base with much of the clinical activity being conducted within various community settings. This revised model of care will require more community home visits and more outreach clinics. Systems, community based facilities and staff training to support this model of care will be developed.

4.7

Organisational Structure

Affected staff have been fully engaged in the ongoing development of this document. A further process of consultation with Service Managers, Clinical Directors and Nurse Consultants to effect the changed leadership structure will begin once the Direction of change is confirmed.

Allied Health Professional representative

An Allied Health Professional Consultant will be recruited into the Leadership teams following confirmation of the Direction of Change.

4.8

Totara House

Totara House review will be delayed until 2013. Staff will be engaged in the process of developing a terms of reference and participating in this review.

Additional Implication

Implications for permanent pool.

- The permanent pool will be utilised by all the functions which use an after hours roster (e.g. inpatient, crisis resolution, mental health consult and liaison, assertive outreach)
- Permanent pool will require resourcing at a level that allows capacity and flexibility to meet fluctuating demand, training and orientation needs.
- It is envisaged that some allied health staff will be employed in the permanent pool.

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.

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.

It is not the intention to reduce staff numbers, but some staff may be required to work in different locations and in some cases modified roles. The SMHS will work with potentially affected staff and their unions as per the relevant MECA.

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.

Under the proposed new service model, psychiatrist time will be split across settings with a registrar per community function and a registrar and house surgeon for each acute inpatient ward. Various options are currently being considered on how these objectives may be achieved to maximise continuity, efficiency and cover. However, each team will have it's own group of psychiatrists who work co-operatively together and cover each other on leave.

Consultation with SMOs will continue throughout the process.

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 though 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 time lines.

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 on 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 The timeframe to complete redeployment / disestablishment of positions will be dependent on other SMHS projects such as the AIS rebuild.
- 5.3.6 Expressions of Interest (EOI) in any of the newly established positions will be made available to potentially affected staff within a designated timeframe. Position descriptions are available on the Mental Health Division intranet. If the interim direction of change is confirmed, affected staff will be given priority for positions as per CDHB practice.
- 5.3.7 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.
- 5.3.8 If potentially affected staff do not wish to apply for the newly established positions, they can signal their interest in other positions to the Line Manager who will work with the Human resource Advisor to ensure they are given prioritisation.
- 5.3.9 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 Employment Collective Agreement, 1 April 2010; Section 38 of the PSA 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

As services change and further develop, 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.

It is envisaged that some training will be inclusive of SMHS, PHO and NGO staff and will enhance partnerships and working relationships across the wider mental health sector.

Training through regular in-services and focussed sessions to promote consistency in practice and a collective understanding of the consumer centred, family inclusive and recovery focussed philosophies underpinning the model of care will be ongoing.

6 INTERIM DIRECTION OF CHANGE CONSULTATION

Feedback from staff, unions and interested parties is required to be submitted to Sharryn Sunbeam, PA to the Divisional Leadership Team (DLT) by close of business on 9 March 2012

The feedback will be considered by the DLT comprising the General Manager, Chief of Psychiatry, Director of Nursing, Allied Health Professional Leader and the Operations Manager. The DLT will consult with Maori, Consumer and Family advisors.

The final Direction of Change will be released on 23 April 2012

7 CONCLUSION

The Interim Direction of Change document is the result of a clinically led stakeholder inclusive, strategic planning process. The Proposal for Change document elicited a large number of submissions which have all been carefully considered and where possible, suggestions have been included in this document. This Interim direction of change will enable us to improve our responsiveness to those who use mental health services, their families and our community.

This document is an interim Direction of change and your feedback is welcome. Consultation is ongoing and as yet no final decisions have 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 the 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

26 January 2012	Interim Direction of Change released
	Interim Direction of Change forums:
3 February 2012	2.00 – 3.00pm, Lincoln Lounge, Hillmorton
9 February 2012	9.00 – 10.00am, Fountain Room, Hillmorton
17 February 2012	1.00 – 2.00pm, Fountain Room, Hillmorton
23 February 2012	10.00- 11.00am Fountain Room, Hillmorton
Consumer forum	TBA
Family & whanau forum	TBA
Provider Forum	TBA
09 March 2012	Submissions close on Interim Direction of Change
23 April 2012	Final Direction of Change decision released
23 April 2012	Change Process commences

Sandra Walker, General Manager
Sue Nightingale, Chief of Psychiatry
Stu Bigwood, Director of Nursing
Rose Henderson, Allied Health Professional Leader
George Schwass, Operations Manager

Glossary

SMHS	Specialist Mental Health Services
NGO	Non-governmental organisation
AIS	Acute Inpatient Service
AIS Rebuild	Reconfiguration of Te Awakura Adult Inpatient ward from three inpatient areas to four inpatient areas each with a high dependency area.
CMHT	Community Mental Health Team
DLT	Divisional Leadership Team
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.

CAPA – Choice and Partnership Approach.

This approach aims to engage rapidly with those seeking access to services, to establish what is the best way to address the person's current needs. Within the context of the Adult Services Proposal for Change, the "best way" may be recommended from within the range of options across the whole Canterbury sector, i.e. primary health, NGO, peer support, SMHS, or a combination. CAPA is a collaborative and strengths-based approach, and contrasts with a "one-size-fits-all" system where everyone must go through a full specialist assessment as a first point of access.

Community Clinic

A CMHT operating in the community but not in a hospital campus e.g. GP practice, Family Health Centre, NGO facility, former community mental health base

"Facilitate engagement"

This would involve the triage worker initiating a conversation (or a series of conversations) with provider/s from elsewhere in the sector in order to arrange and/or facilitate the consumer's engagement with the appropriate service.

"Most socially inclusive"

This concept is a strengths-based extension of the idea of providing services in the "least restrictive environment". It shifts the focus from locks and doors, to considering a socially inclusive culture for how services are delivered. This approach

supports family, whanau-inclusive practice and a better integration of shared service provision across the spectrum of primary health, NGO, peer support, and specialist services.

“Out of Hours”

Refers to the times outside of usual business hours, which in the context of this plan are Monday-Friday, 8:30am to 5pm. “Out of Hours” is therefore overnight from 5pm to 8:30am (Monday to Friday) and all day/all night Saturday and Sunday.

Referral

A request for service, that may come from the person requiring service themselves, from family, whanau or supporters, an NGO, a GP or primary health worker, an SMHS service, and/or another mental health and addictions service (e.g. from another district).

What is Peer Support?

In April 2009 in Christchurch, Te Pou and the Mental Health Commission held a National Peer Support Forum to discuss the development of purposeful peer support work and its workforce. A report on the resulting understandings about peer support can be found on the Te Pou website, and an excerpt is provided below:

<http://www.tepou.co.nz/improving-services/peer-support>

“Peer support work in mental health and/or addiction workforce is provided in a purposeful contextual framework. Peer support workers are trained to support people currently experiencing mental illness/distress and/or addiction issues towards wellbeing.

- It is non-clinical.
- It is not a treatment.
- It is optional – people cannot be compelled to use it.

“Peer support is person-centred and underpinned by recovery and strength-based philosophies. The life experience of the worker creates common ground from which the trust relationship with the person is formed. Empowerment, empathy, hope and choice along with mutuality are the main drivers in purposeful peer support work. There is great deal of strength gained in knowing someone who has walked where you are walking and who now has a life of their choosing. In this way it is different from support work, it comes from a profoundly different philosophical base.”

Peer Support within SMHS

Mutual support by people with lived experience of mental illness or distress is not new; however, over the past several years this has developed into the concept of “purposeful peer support”, and a number of service user-led services providing this have emerged. As the capacity of purposeful peer support services has grown, along with awareness of its benefits, Canterbury service users have increasingly fed back to SMHS a desire for more access to this service.

Within the current adult inpatient services, two different Canterbury providers attend the wards each week to offer a form of purposeful peer support, and to make connections with inpatient service users that can continue to support them following discharge.

Peer support has enormous potential to profoundly influence a recovery approach in services, and as such is highly congruent with SMHS’s Framework Principles of being “1. Service user centred, 2. Recovery focussed, and 3. Responsive and flexible” (SMHS Framework for Mental Health and Wellbeing, 2010). However, one of the difficulties in providing purposeful peer support within a clinical setting is the tension

between clinicians' understanding of the peer role, and how the peer workers themselves understand their work (Scott et al, 2011*).

Submissions on the Proposal for Change have expressed support for increasing the role of peer support within SMHS. In order to do this and to better access the potential for integrating a recovery approach to specialist adult services, however, further discussions are required to ensure that clinicians, leaders and service users are on the same page about:

1. the purpose of peer support within SMHS
2. what kind of organisational structure will best support the agreed purpose

Peer Support and Recovery

“Every District Health Board in Aotearoa New Zealand currently offers some form of peer support, even if in small amounts. This is part of a growing commitment to place ‘recovery’ at the heart of the mental health system. There are two types of recovery in relation to mental illness. The first is recovery in the sense of restoring previous functioning and reducing symptoms. Peer support operates with recovery in its second meaning, which comes out of the civil rights, independent living and mental health consumers’ movements. This understanding of recovery makes the powerful claim that, regardless of the symptoms one may be experiencing, everybody has the right and the possibility of living well. Recovery in this sense is inherently political, and has a multi-layered meaning. It might be seen as a synonym for ‘deep learning’. Recovery doesn’t usually ‘just happen’. The conditions and environment for this form of recovery have to be actively created. This is a role that peer support plays, within the recovery orientated services of the mental health sector as a whole.

“...When peer support is practiced within clinical settings, it has led not just to greater acceptance for peer support, but also to a difference in the way that clinicians think about service users and their recovery in general.”

Scott, A., Doughty, C., Kahi, H. (2011). *Peer Support Practice in Aotearoa New Zealand*. Christchurch: University of Canterbury
<http://www.mhc.govt.nz/sites/mhc.govt.nz/files/Peer%20support%20practice%20in%20Aotearoa%20New%20Zealand-%20Final.pdf>