

Mental Health Services Strategic Plan 2006-11

“Taking Stock and Moving Forward” Progress Report

December 2008

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I Executive Summary

The CEO of Mental Health Services (MHS) commissioned a “stock take” of the MHS Strategic Plan 2006-11. The Plan has reached its mid way point and it is timely to assess the extent to which it has been implemented, to understand what has been achieved and what further effort is required in completing implementation of the essential elements of the Plan.

The CEO nominated a project team to undertake the “stock take” which was to include a review of relevant documentation, discussion with proponents of the Plan and a consultation process with staff and stakeholder groups, to assess the extent of its implementation.

A significant response was received from staff and stakeholders through written feedback and submissions and through input at consultation forums held in each area of the state.

In summary the “stock take” found the following;

- The MHS Strategic Plan 2006-11 encapsulates a significant reform agenda which incorporates national strategic directions and the findings from a number of Tasmanian reviews and reports, including the Bridging the Gap Report 2004.
- The Plan contains a large and dynamic program requiring a considerable change process and is a pivotal document in guiding the delivery of services to people with mental illness. It has a focus on attaining the best outcomes for consumers, their families and carers, and providing a supportive environment that enables staff to provide the best possible care.
- At the outset the Plan provided a significant focal point and impetus for progressing a range of changes aimed at developing a contemporary mental health service.
- There is widespread knowledge of the existence of the Plan and fairly broad support for its principles. Many of those surveyed tended to view the Plan as useful in providing a framework but of less value in supporting service delivery on the ground. Some clinicians thought it more important that processes and structures were put in place to provide tangible differences for consumers, carers and the community in the delivery of mental health services.
- While there was good initial progress, implementation of the Plan appears to have faltered due to personnel changes and an inability to quickly fill positions designed to support the implementation process. Consequently, timeframes have drifted and key supporting documents have been delayed. As a result there is confusion in the field about the intent of some of the key elements of the Plan. This has fuelled resentment that some elements of the plan were imposed and were not appropriate for all areas of the service.
- Some stakeholders considered the Plan contained rhetoric which had not been matched by supporting or intended actions. It became apparent to the Project team that there is a strong need to work on the interface between MHS and its supporting community based services, to ensure appropriate clinical pathways, case management and an understanding of and respect for roles.

- The key elements of the model of care are viewed inconsistently across the state and among service streams and clinical disciplines. Assertive case management is not well understood and the recovery focus is not recognised as valid for all clinical streams or disciplines. As a result some teams are having difficulty progressing new models of care and struggling to meet the demands of providing care to a complex client group.
- There is a view that the level of resourcing provided does not facilitate the case management role proposed under the new model of care. Consequently, it has become increasingly difficult to meet the needs of clients with a severe mental illness. Additionally, it has also become difficult to identify appropriate discharge options for some clients, leading to a tendency for these clients to continually cycle through the range of services and increasing the potential for bed blockage in acute and extended treatment facilities.
- Resourcing constraints were also identified, by some staff and community sector organisations, as inhibiting the progress of service delivery in line with the Plan.
- There is a need to develop better information capacity and indicators to enable the measurement of progress, including tangible outcomes for clients. There is also a need to clearly communicate the key elements of the Plan and the intended actions.
- The Project Team noted a need to identify clear accountability for implementing the various strategies contained in the Plan, as well as the need to adopt robust project management principles to ensure that implementation proceeds as planned. It is also noted that further implementation of the Plan will need to be incorporated within the recently endorsed clinical governance framework, with the clinical specialty groups and clinical governance groups having a key role.
- The development of an internal action plan, endorsed by the MHS Executive Committee, which identifies accountability for progressing each of the recommendations stemming from the “stock take”, is recommended. In essence, this will involve a number of working groups being established to progress each strategic priority. It is noted that the Manager Service Development has a key role in facilitating the implementation of the Strategic Plan. This position will be pivotal in supporting the recommended process.
- In 2008 the Department of Health and Human Services was significantly restructured with the aim of maximising client outcomes through service integration, resulting in the creation of a new MHS. On this basis it may be prudent to clearly identify and prioritise the intended actions to progress the current Strategic Plan, while at the same time considering whether a process should be commenced to develop a broader Strategic Plan more inclusive of the services now encapsulated within MHS.
- There are also emerging policy shifts such as social inclusion and the greater focus on promotion, prevention and early intervention nationally and at a state level, which reinforces the need to treat the current Strategic Plan as a “living” document that should be revised in accordance with national and state policy agendas.

A series of recommendations have been developed in response to the “Key Findings” as specified in this report and are provided on page 25.

2. Introduction

MHS has progressed a significant reform agenda through the Strategic Plan 2006-11. The Plan contains a large and dynamic program requiring a considerable change process and is a pivotal document in guiding the delivery of services to people with mental illness. The Strategic Plan incorporates outcomes from the Bridging the Gap Report 2004 and national and state health agendas. The Plan is about getting the best outcomes for consumers, their families and carers and providing a supportive environment that enables staff to provide the best possible care.

The Plan is now at its mid way point and it is considered timely to assess the extent to which the plan has been implemented, and determine what further effort is required to finalise implementation of the Plan and its key strategies.

Further impetus for assessing progress has been provided with the appointment of a new CEO for MHS, who is keen to understand what has been done to date and what further effort is needed. Consequently, it was determined a “stock take” should be undertaken to assess progress against the Strategic Plan and enable the development of an internal action plan to consolidate remaining effort.

3. Background

The Strategic Plan was developed following a number of reviews instigated during 2004 most notably the Bridging the Gap Report 2004, the Thin Ice Report (Anglicare) and the Health Complaints Commission Review of Ward 1E. Generally the reviews made similar recommendations about the service approach to Tasmanians who experience mental illness.

Following the release of the Bridging the Gap Report 2004, a draft of the Strategic Plan was finalised in September 2005 and consultations were conducted around Tasmania. The Strategic Plan was launched in February 2006 identifying eleven service principles to underpin the delivery of mental health services and six priority areas, with major strategies and success measures to guide implementation.

In conjunction with the release of the Strategic Plan, the Consumer and Carer Participation Framework and service blueprints were developed for each of the mental health service streams. Firstly the service blueprint for the Adult Community Mental Health Services (ACMHS) was produced followed by Child and Adolescent MHS (CAMHS), Older Persons MHS (OPMHS), Inpatient and Extended Treatment MHS (IETS) and the Non Government Services blueprint. The ACMHS blueprint was finalised to coincide with the launch of the Strategic Plan.

The development of a new model of care for MHS is a fundamental component of the reform process being driven by the Strategic Plan. This has involved the integration and provision of crisis response, case management, intensive support and rehabilitation in all adult community teams. It has a strong focus on recovery, assertive case management in least restrictive environments, multi-disciplinary teams and the development of individual care plans in close collaboration with clients.

The new model of care has been supported by the implementation of a consistent statewide triage and service response capability for clients of all ages. The MHS Helpline was established for this purpose and since commencing operation has consistently received a high number of calls.

4. Process

The “stock take” was undertaken by a project team and comprised:

- a. Contextual discussion with key people involved in the development of the MHS Strategic Plan 2006-11;
- b. Completion of staff and key stakeholder surveys;
- c. Facilitation of staff and key stakeholder consultation forums;
- d. Consideration and review of relevant documentation, literature and previous service reviews;
- e. Thematic analysis of data; and
- f. Completion of a final report, including recommendations and an internal action plan, to focus future effort and implementation of recommendations.

5. Terms of Reference

The broad terms of reference for the “stock take” were as follows:

- a. Assessment of progress made in implementing the Strategic Plan 2006-11 as at the halfway point of the Plan. In particular assessment of progress against success measures and major strategies;
- b. Determination of further action required in implementing the Strategic Plan 2006-11 and development of an internal action plan to consolidate remaining effort.

6. Scope

The “stock take” focussed on Tasmanian government mental health services and non government organisations, including consumer, carer and service provider organisations funded by MHS.

7. Methodology

a. Contextual discussions with key people involved in the development of the MHS Strategic Plan 2006-11

To gather background information, in relation to the development of the Plan and the intended implementation process, discussions were held with key people involved in the development of the MHS Strategic Plan 2006-11.

b. Staff and Key Stakeholder Surveys

A questionnaire was provided to staff and a number of key stakeholders to obtain feedback in relation to the implementation of the Plan. Questionnaires were provided online to staff and posted to stakeholders to enable return by reply paid envelope.

A total of twenty nine (29) staff surveys and nine (9) stakeholder surveys were received.

c. Staff and Key Stakeholder Consultation Forums

A total of twenty (20) consultation forums were held statewide. One hundred and eighty eight (188) staff and twelve (12) key stakeholders participated in the consultation forums. Two (2) staff also requested individual meetings with the Project team.

d. Consideration and review of relevant documentation, literature and previous service reviews

Documentation, literature and previous service reviews relevant to the MHS Strategic Plan were considered as part of the “stock take” process.

e. Thematic Analysis of Data

All data from staff and key stakeholder feedback surveys, consultation forums and other sources was noted, subjected to an aggregation of common themes and reported as “Key Findings” in this report.

8. Key Findings

In detailing these findings it is acknowledged a significant amount of work has been undertaken in progressing the Plan and this should be recognised at the outset.

Set out below are the commonly expressed views of staff and key stakeholders who provided feedback through the “stock take” process. Individual view points are not highlighted in this report as the key findings are based on a thematic analysis of commonly expressed views.

Generally there was a relatively high recognition of the existence of the MHS Strategic Plan 2006-11 and considerable support for the Plan and its Principles as providing a broad framework offering direction for MHS. However, there was a recurring theme that the Strategic Plan had not been systematically implemented, in the sense that there had been a lack of ongoing project management resulting in time frame slippage and key documents not being delivered as intended. This has made it difficult to achieve a shared understanding of the critical elements of the model of care.

Recognition of the Plan, as a relevant document for service delivery, was highest at executive level within MHS. Services providing direct care, particularly inpatient units, did not consider the Plan to have direct relevance to their everyday operation. It was suggested there was a need for supporting documentation which enabled the operationalisation of the Plan, as it was considered the blueprints did not provide the level of detail required. In addition, a view was widely expressed that the Plan focussed primarily on ACMHS and this had resulted in a lack of clarity and direction for staff in other clinical streams.

The service principles were also generally considered to be principles to which MHS should be aspiring. However, some staff and stakeholders considered they were not well defined encouraging individual interpretation and application. In particular, the service principles of comprehensive service, mainstreamed and single point accountability were highlighted as requiring further definition. Some stakeholders also considered that the service principles were not reflected in the service delivery of MHS.

Feedback was provided in relation to the application of the service principle “early intervention and assertive case management”. A view was held that MHS had positioned itself as providing services to the 3% of the population with serious mental illness, in doing so it was considered the focus on early intervention had been lost.

Some stakeholders expressed concern in relation to the service principle “customer focussed” and the corresponding commitment in the Plan to establishing a committee to have ready access to customer feedback in relation to service quality. At the half way point of the Plan this committee has not been convened.

8.1 Strategic Priority I – Model of Care:

Goal for 2011 – A Tasmanian model of care for mental health that is centred on consumers, promotes their recovery, and is provided equitably and efficiently.

Success Measures:

By 2011, our success in this area will be demonstrated by significant progress in the following:

- 1. A standard model of care throughout MHS.**
- 2. Consumers, carers and partners have a clear understanding about the role and responsibility of MHS, the services it directly provides and where it adds value to other services through consultation and liaison.**
- 3. Improvement in the health of people with mental illnesses as evidenced by key indicators.**
- 4. Strong consumer and carer focus in all services, with every mental health consumer having an individual plan which they have collaboratively developed.**
- 5. Staff of MHS are confident in the model of care and their individual role in it, demonstrated by an increasingly skilled workforce reporting increased satisfaction as individual staff and as a team.**
- 6. MHS is working effectively with a range of partners in providing services.**

Major Strategies:

- 1. Build a comprehensive model of care based on population based data, research and evidence where available.**
- 2. Implement a carefully staged and detailed Transition Plan that aligns services to the model of care.**
- 3. Establish a reward and recognition strategy to support staff who demonstrate leadership in progressing towards the goals established within this strategic plan.**
- 4. Develop and implement a strategy to involve consumers, carers, partners and others in the development of the model.**

A thematic analysis of the data obtained suggested the following key findings in relation to the success measures and major strategies for Strategic Priority I- Model of Care:

8.1.1 Model of Care

- It is evident that a significant number of staff and key stakeholders do not consider there is a standard model of care. Feedback provided suggested a lack of common understanding and shared interpretation of the model of care.

- Based on the information presented throughout the “stock take” process it does not appear that a detailed Transition Plan, aligning services to the model of care, has been implemented as a key strategy. This has generated a level of difficulty in assessing progress and tangible outcomes. A range of individual actions has been undertaken in relation to implementation of the Strategic Plan and alignment of services, however there does not appear to have been an overarching systematic approach.
- It was suggested there is a need to develop indicators to measure the performance of MHS in producing outcomes for consumers. This should include the provision of meaningful data to clinicians to assist in client treatment and care. It was also considered important to assess if the model of care was resulting in tangible differences for consumers, carers and the community.
- Concern was expressed in relation to perceived deficits in supported accommodation options and resultant bed blockage, lack of multi-disciplinary staffing models within inpatient units and limited rehabilitation and psycho-geriatric services in the North and North West.
- The interface between community mental health services and inpatient and extended treatment services was considered to need strengthening to improve continuity of care. Strategies were also needed to enable MHS to more effectively engage with key stakeholders. Relationships and linkages between government and community sector mental health services were also considered to require clarification and strengthening.
- Concern was raised in relation to recruitment and retention. In particular, disincentive to work in community teams due to lack of parity of wages with shift staff working in inpatient units and no access to salary packaging. The need to fill medical practitioner and in particular Clinical Director positions on a long term basis instead of using locums to cover the positions was also highlighted.

Feedback provided also suggested uncertainty and concern in relation to particular aspects of the model of care:

8.1.1.1 Recovery Framework

- Concern was expressed that the recovery framework had not been widely communicated and appropriate training had not been provided. Suggestion was made that MHS needed to invest resources and time to support staff in understanding a recovery focussed framework, and its application in providing care and treatment to people experiencing mental illness.
- Some staff considered there was a lack of clarity in relation to the role of inpatient units and the relationship between the perceived “medical model” and the recovery framework.
- Feedback suggested there was some apprehension in applying a recovery framework to all service streams when other models had been evidenced as more appropriate. This was of particular relevance to CAMHS where a developmental model approach was considered to be of greater relevance.

- Concern was expressed that the current application of the recovery framework focussed on throughput and rehabilitation readiness, particularly in the non government sector, and did not provide for the needs of the long term seriously mentally ill.
- Stakeholders considered MHS and the non government sector did not have a shared understanding of a recovery framework and consequently differed significantly in their application of the framework.

8.1.1.2 Assertive Case Management

- Information provided suggested a lack of shared understanding of assertive case management and a lack of clarity in relation to the role of inpatient units in assertive case management. Concern was also expressed at the appropriateness of a “blanket” requirement for all clients to receive assertive case management, when the focus should be on matching service delivery to client needs. Therefore, some staff were struggling to cope with the demands of providing care to a complex client group as well as the challenges of implementing a new model of care.
- There was a view that the current level of resourcing was not sufficient to undertake the case management role as proposed under the new model of care. Consequently, some staff thought it had become increasingly difficult to meet the needs of clients with a severe mental illness. Additionally, it had also become difficult to identify appropriate discharge options for some clients, leading to a tendency for these clients to continually cycle through the range of services, increasing the potential for bed blockage to occur in acute and extended treatment facilities.
- Concern was expressed that the current number of case managers in community mental health teams was insufficient to meet the present demand and provide an appropriate level of care and treatment. In particular, there was a perception that case manager case loads were generally too high.
- Case managers perceived the focus on assertive case management had resulted in case managers becoming “all things to all people” and there was concern this was at the expense of client outcomes.
- Some stakeholders considered there had been a shift towards a more proactive and assertive response from case managers, however it was not often inclusive of non government partners. Feedback suggested the need for strategies to include an understanding of the role of non government organisations in case management.
- Some stakeholders suggested that information regarding the assertive case management framework had not been clearly communicated to consumers, carers and non government organisations. In particular, there was a lack of understanding of how assertive case management should be applied when consumers did not want to engage with MHS.

8.1.1.3 Tools to support the model of care

Feedback suggested there had been a range of tools provided in an effort to support implementation and application of the model of care. However, these tools had been rolled out without context and over an extended period of time rather than as a consistent

cohesive package. Consequently, some staff expressed the view that it was difficult to relate to the range of tools in the context of the model of care. In particular, feedback from staff highlighted the following areas of concern:

- Not all clinical documentation, policies and procedures, required to support the model of care had been developed and implemented.
- Clinical Reference Groups had not been well supported. It was considered there was a need to provide specific clinical forums for clinical streams to facilitate a consistent, statewide and evidenced based approach to care and treatment
- Greater access to computers, telephones, vehicles and consultation rooms was needed for staff, in providing care and treatment to clients. It was acknowledged this had improved however there was still a need for additional resources to enable clinicians to perform their roles.

8.1.1.4 MHS Helpline

The effort that had occurred in establishing the Helpline in a short time frame and the hard work of Helpline staff in operationalising the service accordingly was recognised. It was also generally considered that the MHS Helpline was a positive development, which had facilitated a central reference point for mental health services, provided screening to ensure appropriate referral and had enabled support to be provided to remote areas such as King Island and the West Coast. While generally supported as a positive concept, there were some concerns expressed in relation to the operation of the MHS Helpline. In particular, staff and stakeholders expressed the following views:

- Stakeholders reported a mixed response to the MHS Helpline. Some consumers had reported that the Helpline was very effective while others had expressed concern in relation to the level of service provided.
- There was a need to clearly define the role and function of the MHS Helpline, and to develop corresponding processes of operation and supporting documentation to support the role and function.
- Concern was expressed that there was a need for appropriate categorisation and follow up timeframes to ensure clients are receiving an appropriate response. Information provided suggested that at times the categorisation and follow up was not as prompt as required, and there were varying levels of quality and consistency in relation to the application of category ratings.
- Staff uncertainty existed in relation to the MHS Helpline referral processes. Information provided suggested some community mental health teams were being required to use the MHS Helpline for referral to other community mental health teams. It was suggested the practice was inconsistent and not in keeping with the MHS Helpline being a first point of entry for external referral into MHS. Generally it was considered that MHS staff should be able to refer directly within MHS.
- Feedback suggested more effective after hours operation was needed. Suggestions included regionalising of after hours support and “stand up” night shifts.

- A common view was expressed that there was a need to consider the location of the MHS Helpline to ensure the service was not operating in isolation. In particular, the location and management of the statewide service within the Southern Area and the need for the MHS Helpline to develop familiarity with service availability in the North and North West.
- There was a need to consider the current resourcing of the MHS Helpline. In particular the sufficiency of the current staffing compliment and medical resourcing to provide the statewide triage and referral for all of MHS.
- Support and training needed to be provided to MHS Helpline staff to ensure a level of specialist skill required for working within a triage service and providing a consistent quality of service.
- There was a need to assess the reliability and limitations of the TRIO Database and determine if the operation of the database system and storage of referrals was appropriate.
- A statewide marketing strategy was needed to market the MHS Helpline, with a focus on the North and North West and service providers outside of MHS.

8.1.1.5 Maximising Recovery Panels (MRPs)

There was a spectrum of views expressed in relation to MRPs. Some staff and stakeholders saw benefit in the MRPs as providing a mechanism to ensure consumers were able to access required services while others suggested there were issues with the MRPs. In particular:

- A common view was expressed by staff and stakeholders that MRPs were a cumbersome and unnecessarily bureaucratic referral system, which was disconnected from the reality of service delivery and resulted in significant time delays in consumers receiving services.
- Some stakeholders considered the MRP process lacked transparency in its decision making as the rationale and criteria for determinations was not clearly known. There was further suggestion that the success of the panel was reliant on the approach taken by members and particularly the Chairs of the panels. Similarly, it was considered that the referral process was very much dependent on individual case managers taking a proactive approach to referral.
- Some stakeholders held the view that the use of the MRP process suggested a lack of trust in non government service providers. Specifically that non government organisations cannot manage their own admissions, which is not reflective of a partnership approach.
- Some staff expressed concern in making referrals to MRPs for fear the referral would not be accepted and the client's expectations would not be met.
- Some stakeholders providing statewide services suggested there were differences in the operational procedures of MRPs in the three regions. It was considered for example that the panel in the North often requested additional information for referrals to non government services in comparison to the other regions.

- Stakeholders suggested the role of the non government sector in providing specialist psycho-social care was not understood by some areas within MHS. This was considered to impact on the MRP process. Consequently, MRPs were viewed as a process that hindered admissions to non government service providers or resulted in inappropriate admissions.
- Some staff and stakeholders expressed a view that panel representation on MRPs did not provide for consumer, carer and non government representation and this was not in the spirit of a partnership approach.
- Some non government organisations provided feedback that they sometimes felt pressured to admit consumers to their service, as MRPs decisions were viewed as being at the direction of the funding body.
- Access was considered to be an issue with the current MRPs. Some staff suggested difficulty in accessing MRPs in other regions, limited availability of service options and purported that some consumers were not able to access services through MRPs due to their history.
- Some staff expressed a view that case managers were removed from the MRP process and were not updated in relation to clients on waiting lists and the availability of services in the non government sector.

8.2 Strategic Priority 2 – Participation and Partnerships:

Goal for 2011 – Staff of MHS are working effectively with consumers, carers and partners.

Success Measures:

By 2011, our success in this area will be demonstrated by significant progress in the following:

- 1. Effective participation by consumers, families and carers in mental health services.**
- 2. Services to consumers with families include family sensitive strategies in Individual Service Plans.**
- 3. Effective partnerships and working relationships between MHS, other DHHS services, other government agencies, non government organisations, volunteer groups, education providers and the private sector.**
- 4. Increased capacity of the non government sector to deliver primary health care and other services to specific target groups.**
- 5. Improved synergy of efforts in responding to mental health needs in Tasmania through an increasing number of joint and collaborative ventures.**

Major Strategies:

- 1. Implement the Consumer and Carer Participation Framework.**
- 2. Implement a family sensitive service delivery framework.**
- 3. Build strong foundations for establishing, maintaining and sustaining partnerships including establishment of agreed consumer outcomes.**
- 4. Establish monitoring and review processes for formal partnerships.**
- 5. Include consultation and participation strategies in all major service activities and projects.**

A thematic analysis of the data obtained suggested the following key findings in relation to the success measures and major strategies for Strategic Priority 2 – Participation and Partnerships:

8.2.1 Consumer and Carer Participation

- Feedback provided suggested staff had little understanding of the consumer and carer participation framework. Stakeholders considered a strong consumer and carer participation focus was not prevalent in all services. In particular, every mental health consumer did not have an individual plan which they had collectively developed with mental health clinicians. Staff and key stakeholders saw the need and value in creating greater levels of consumer and carer participation within mental health services.

- Some stakeholders expressed a view that there was a need for consumer participation beyond the individual consumer and at a broader level. It was considered this should occur through consumer driven and consumer controlled mechanisms, such as mental health consumer advocacy focussed on the improvement of the mental health system.
- The recent appointment of the statewide Senior Consumer and Carer Liaison Consultant, to review and implement the Consumer and Carer Participation Framework, was considered to be positive.

8.2.2 Family Sensitive Practice

- Some staff and stakeholders provided feedback which suggested positive efforts toward family sensitive practice. Some stakeholders suggested they had received favourable comments from carers who had positive relations with case managers. Other stakeholders reported instances where family members, involved in the care of the person receiving services, did not know the names of case managers. It was also recognised that there was a need for improvement in the inclusion of families in care planning when it was considered to be clinically appropriate.
- A view was also expressed by staff and stakeholders that family sensitive practice was not a systematic part of service delivery throughout MHS. There was a need to gauge the application of family sensitive practice and address areas of deficit.

8.2.3 Partnerships

- There was a mixed response from staff in relation to the role of non government organisations in the delivery of mental health services. Some staff considered non government organisations had a valuable role to play in the delivery of mental health services but support was required from MHS to ensure the quality of service delivered. Others raised concerns in relation to the capacity of the non government sector to deliver services to consumers with high needs.
- Some non government organisations did not believe they were regarded as “true” partners. Both staff and stakeholders considered there was still a significant amount of work to be done to develop “true” partnerships.
- Some stakeholders suggested there was a lack of recognition of the non government mental health sector as a specialised psycho-social support system, which is additional to clinical services. Instead the non government sector was viewed as an extension of MHS requiring management and control by MHS.
- Stakeholders perceived there was limited consideration of the resourcing required to support the non government mental health sector.
- Stakeholders expressed the view that there is a divide between MHS and non government service providers due to a lack of professional respect given to the mental health non government sector. Some stakeholders suggested that MHS case managers held the belief that they were the “experts”. It was also suggested there was a lack of understanding in relation to non clinical models of practice and in some instances case managers actively discouraged the exploration of other practice models.

- Staff and stakeholders expressed difficulty in maintaining awareness of services, support groups and activities relevant to the mental health sector and available to the community.
- It was also suggested there was a need for Memorandums of Understanding (MOUs) between MHS and a range of government service providers in order to provide for appropriate collaboration and co-ordination of services.

8.3 Strategic Priority 3 – Governance and Leadership:

Goal for 2011 – Sound governance and effective leadership throughout MHS, so that the efforts of everyone are focussed on recovery and the promotion of mental health.

Success Measures:

By 2011, our success in this area will be demonstrated by significant progress in the following:

- 1. Well structured governance processes and systems with single point accountability at all levels through the organisation and individual performance management plans in place.**
- 2. Contemporary clinical management and supervision practices that rate well when compared with available evidence.**
- 3. Regular and useful communication of information occurring throughout MHS.**
- 4. A strong culture of leadership and teamwork leading to a positive and functional organisational culture.**

Major Strategies:

- 1. Develop a governance structure, systems and processes that support the model of care.**
- 2. Ensure the capacity for accountable governance, leadership and teamwork within the senior management team.**
- 3. Implement a professional and clinical supervision framework.**
- 4. Implement a performance management system.**
- 5. Providing training and mentoring opportunities.**

A thematic analysis of the data obtained suggested the following key findings in relation to the success measures and major strategies for Strategic Priority 3 – Governance and Leadership:

8.3.1 Governance Structure

It was considered the governance structure for MHS required further development and implementation. In particular, there was a need to strengthen the clinical governance framework. Feedback also suggested support for the re-invigoration of forums for clinical streams within MHS (clinical reference groups).

8.3.2 Clinical and Professional Supervision

The introduction of the clinical supervision framework and the accompanying training was considered a good starting point. Concern was however raised in relation to the implementation and resourcing of clinical supervision particularly in inpatient units.

8.3.3 Performance and Management Framework

Participants noted a performance management framework existed within the Department of Health and Human Services and many staff had completed the “positively managing people” program. However, implementation of the framework throughout MHS was not well advanced.

8.4 Strategic Priority 4 – Workforce Development:

Goal for 2011 – A highly skilled mental health workforce providing specialist services in line with the model of care and its underlying principles.

Success Measures:

By 2011, our success in this area will be demonstrated by significant progress in the following:

- 1. Increased participation by staff in workforce development activities with corresponding increased skill development and capacity across the mental health sectors.**
- 2. Implementation of the National Mental Health Workforce Practice Standards.**
- 3. Workforce practice is underpinned by research and evidence where available.**
- 4. Staff understand and adopt appropriate Clinical Practice Guidelines.**
- 5. High level of staff participation in professional and clinical supervision.**
- 6. High level of participation in the performance and development program.**
- 7. The establishment of a dedicated budget for workforce development.**

Major Strategies:

- 1. Develop and implement a comprehensive workforce development and innovation plan, in line with the model of care and National Mental Health Workforce Practice Standards.**
- 2. Build appropriate infrastructure to allow easy access in the workplace to research and evidence based practice.**
- 3. Cost requirements for training and clinical supervision, so that dedicated resources are identified and quarantined for the life of this Strategic Plan.**
- 4. Submit a business case for additional funding to support workforce development.**

A thematic analysis of the data obtained suggested the following key findings in relation to the success measures and major strategies for Strategic Priority 4 – Workforce Development:

8.4.1 Professional Services Unit (PSU)

Establishment of the PSU and the development of an annual training calendar were considered positive steps for MHS. However, concern was expressed that PSU staffing resources were not sufficient to deliver all the training required.

Concern was expressed that PSU was located in the south of the state and, instead of a centralised education and training system, there was a need for training to be provided from within the regions.

8.4.2 Training Provision and Identification of Needs

Concern was expressed that discipline specific and advanced training requirements were not being addressed, and training was not being targeted appropriately to fit the varying skill levels of staff. Instead it was perceived that some training was pitched at the lowest common denominator, which was not always appropriate for experienced clinicians. It was also suggested that the capacity to provide onsite training needed to be considered in an effort to address staff attendance difficulties.

Some staff suggested there was a need for an assessment process to identify training needs of all MHS staff (clinical and non clinical) and to determine the training to be undertaken. Concern was also expressed in relation to the determination of the current core competencies and the need for the rationale and criteria to be communicated to staff.

Feedback identified the need for workforce planning particularly given the issue of an ageing workforce. It was suggested mental health scholarships for nursing and allied health staff and introduction of entry level allied health positions within MHS could assist.

8.5 Strategic Priority 5 – Quality and Safety:

Goal for 2011 – Mental Health Services deliver high quality, safe services to customers.

Success Measures:

By 2011, our success in this area will be demonstrated by significant progress in the following:

- 1. Staff and management understand and are committed to the value of quality and safety systems in providing services.**
- 2. Effective risk management strategies are developed and implemented.**
- 3. Well structured clinical governance is in place.**
- 4. Outcomes measures for consumers and for service delivery are routinely monitored and evaluated in an environment of continual improvement.**
- 5. MHS Tasmania is fully accredited against National Standards for Mental Health Services.**

Major Strategies:

- 1. Develop and implement a comprehensive Quality and Safety Plan which is aligned with national priorities and the Agency Quality and Safety Plan including easily understood tools and processes.**
- 2. Implementation of a standardised, comprehensive suite of clinical policies and procedures to guide service delivery to customers.**
- 3. Put in place processes to monitor and review key quality and safety outcome measures.**

A thematic analysis of the data obtained suggested the following key findings in relation to the success measures and major strategies for Strategic Priority 5 – Quality and Safety:

The National Reducing Seclusion and Restraint Project (The Beacon Project), implementation and roll out of the Electronic Information Management System (EIMS), accreditation and review against national standards and mandatory training in relation to aggression management (MAPS and P3) were considered to be positive quality and safety monitoring and review measures, which had been implemented within MHS.

Other comments provided in relation to the MHS quality and safety agenda comprised:

- The need for the development and implementation of an appropriate clinical governance framework for MHS, including the revitalisation of the previous clinical reference groups to support clinical practice development.

- The requirement for finalisation of processes to enable ongoing accreditation of MHS against relevant health care standards.
- An urgent need for the development of statewide policies and procedures which supported the model of care and considered national, state and local requirements, mental health standards and legal requirements. It was acknowledged that some clinical documentation had been developed such as risk assessment tools and individual service plans, which were being trialled in Southern MHS, and case review policies and procedures, which were being trialled across ACMHS. However, roll out of this documentation had not been systematic and lacked context.
- The requirement for a systematic review and audit of policies and procedures and the need to ensure all current policies and procedures were easily accessible by staff.

8.6 Strategic Priority 6 – Sustainable Resources:

Goal for 2011 – Responsible and efficient use of a sustainable funding base that maintains the infrastructure and highly skilled staff required to meet service needs.

Success Measures:

By 2011, our success in this area will be demonstrated by significant progress in the following:

- 1. Realistic and accurate population based funding model used as the basis for service and resource distribution.**
- 2. Clear understanding of emerging needs, gaps and proposed responses and the ability to respond quickly as priorities change.**
- 3. Tasmania is seen as a rewarding and satisfying place to work by health professionals and other staff locally, nationally and internationally.**

Major Strategies

- 1. Implement a population based planning model that will enhance the current service system by matching services to need.**
- 2. Develop and implement a performance and business monitoring system in MHS.**
- 3. Delegate responsibility for resource management as close to service delivery as possible.**

A thematic analysis of the data obtained suggested the following key findings in relation to the success measures and major strategies for Strategic Priority 6 – Sustainable Resources:

8.6.1 Population Based Planning

Feedback suggested that MHS was still formative in its approach to population based planning. It was also suggested that population based planning needed to consider an index of socio economic factors, acuity and changes to demographics such as ageing populations.

8.6.2 Performance and Business Monitoring

- Concern was expressed that the MHS business monitoring system is not currently linked to a performance monitoring system. Consequently, this impacts on the ability of MHS to identify inefficiencies in service delivery and provide appropriate solutions. It was suggested the linking of these systems may provide some scope for greater service efficiencies.
- The urgent need to broadly implement an appropriate clinical information system was noted due to a range of issues relating to the current use of the Outcomes Assessment and Review System (OARS).

9 Discussion

9.1 Strategic Priority 1 - Model of Care

As reported in the “Key Findings” there was overwhelming feedback to suggest the model of care requires reassessment. In particular there is a need to consider how the model provides for all spectrums of service provision within the continuum of care (inpatient and extended treatment care, community care, and psycho-social rehabilitation) and how it provides for the needs of all client groups (child and adolescent, adult and older persons). Additionally, information provided suggested the recovery and assertive case management frameworks require clarity and context as a component of the model of care.

In relation to services and processes that support the model of care, specific information was gathered in relation to the MHS Helpline and the MRPs.

Generally the MHS Helpline was considered to be an initiative which had the potential to enhance service delivery although there were a range of areas identified as requiring further development. While a variety of views were provided in relation to the MRPs, in particular some staff and stakeholders saw benefit in the MRPs as providing a mechanism for ensuring consumers were able to access required services. Others suggested there were issues in relation to referral process time frames, capacity for consumer informed care, access to services, panel representation and involvement of case managers and other key stakeholders.

9.2 Strategic Priority 2 – Participation and Partnerships

The Consumer and Carer Participation Framework has not been implemented. Consequently, services are attempting to provide for consumer and carer participation at an individual service level as opposed to a systematic approach operating throughout MHS. Similarly, there also appears to be an individual service approach to family sensitive practice.

In addition, the Minister for Health and Human Services has requested MHS undertake a statewide review in relation to mental health consumer and carer participation within Tasmania. The review will identify an optimum model for consumer and carer participation consistent with MHS Strategic Plan 2006-11, National Standards for Mental Health Services, National Mental Health Plan 2003–2008 and the MHS Consumer and Carer Participation Framework.

The area of partnerships generated a gamut of feedback. In particular, the need for the development of “true” partnerships with non government organisations, including the consideration of resourcing implications for non government mental health services and formal partnership arrangements with other government organisations.

9.3 Strategic Priority 3 - Leadership and Governance

There is a clear need for a strong and robust clinical governance framework to drive clinical practice and other related components of the Strategic Plan. Feedback focussed on the need for an appropriate and effective clinical governance structure, and the systematic implementation and resourcing of clinical and professional supervision and performance development agreements throughout MHS.

9.4 Strategic Priority 4 - Workforce Development

Information provided suggested a need for an appropriate process for determining training priorities and consideration of requests for training and professional development. Findings also suggested a need for recruitment, retention and workforce planning strategies for MHS.

9.5 Strategic Priority 5 - Quality and Safety

Findings suggested the need for an appropriate clinical governance framework for MHS and ongoing accreditation and review against relevant health care standards. Findings further suggested the urgent need for the development of statewide policies and procedures to support the model of care.

9.6 Strategic Priority 6 – Sustainable Resources

As reported in the ‘Key Findings’ MHS is still some way off implementing an appropriate system of population based planning which provides for consideration of all relevant factors. Additionally, there is a need for MHS to consider linkage of performance and business monitoring systems.

Having considered the feedback received the project team identified actions which could be taken to enable progression of strategies to achieve intended outcomes.

10 Recommendations

10.1 General

- 10.1.1 That the MHS Executive assign clear accountability for implementation of the MHS Strategic Plan 2006-11.
- 10.1.2 That a detailed plan for implementing the Strategic Plan be developed and actioned providing for all key aspects of project management.
- 10.1.3 That an appropriate governance structure for implementing the Strategic Plan be identified and implemented. This should include the establishment of working groups to action recommendations for each of the Strategic Priorities.
- 10.1.4 That indicators of progress in implementing the Strategic Plan and achieving tangible outcomes for consumers be identified and reviewed on an annual basis.
- 10.1.5 That a communication strategy be developed and implemented to enable clear communication of the key elements of the Plan and the intended actions.
- 10.1.6 That State Office for MHS clearly articulate its role in progressing service wide initiatives and supporting effective communication across MHS.
- 10.1.7 That consideration be given to the development of a new Strategic Plan inclusive of all services now encapsulated within MHS (Alcohol and Drug Service, Mental Health Service, Correctional Primary Health Service and the Forensic Mental Health Service).

10.2 Strategic Priority 1 - Model of Care

- 10.2.1 That the model of care be reassessed to consider all contexts of care, all client groups and the role of the non government sector in the provision of specialist non clinical mental health services. The reassessment of the model of care should also consider the following additional recommendations:
 - 10.2.1.1 That the recovery framework and its application, as a component of the model of care, be clearly defined.
 - 10.2.1.2 That the assertive case management framework and its application, as a component of the model of care, be clearly defined.
 - 10.2.1.3 That the model of care provide for the strengthening of relationships between community mental health services and inpatient and extended treatment services and relationships and linkages between government and non government mental health services.
 - 10.2.1.4 That MHS develop mechanisms to work in partnership with the non government sector to define their role within the model of care, including the recovery and assertive case management frameworks.
 - 10.2.1.5 That consideration be given to the role and configuration of case managers within the context of the broader model of care, including

the need for specialist intervention based on the role of the specialist discipline.

- 10.2.1.6 That current case loads for case managers be reviewed to establish base line case loads (including all variables). That a process to monitor and review case loads and effectively manage waiting lists and demand pressures be implemented.
- 10.2.1.7 That clinical documentation required to support the model of care be developed as a priority and disseminated in a consistent form, with appropriate communication and education provided.
- 10.2.1.8 That current access of staff to computers, telephones, vehicles and consultation rooms be reviewed, including further consideration of resourcing implications.
- 10.2.1.9 That MHS develop performance and outcomes indicators and include the provision of meaningful data to clinicians to assist in client treatment and care.
- 10.2.1.10 That the model of care be communicated to staff, consumers, carers and other key stakeholders and that education and training in relation to the key components of the model of care be provided.
- 10.2.1.11 That the MHS Executive determine accountability for progressing the model of care and further consideration of the model of care be assigned to speciality clinical reference groups.

10.2.2 MHS Helpline

- 10.2.2.1 The role and function of the MHS Helpline be clearly defined (including clarification of access points for crisis and after hours response to key stakeholder groups) and corresponding processes and supporting documentation be developed and implemented to support its role, function and operation.
- 10.2.2.2 That options to better integrate the work of the MHS Helpline be considered as well as strategies to provide for extended hours coverage.
- 10.2.2.3 That resourcing requirements to operate an effective statewide Helpline and Triage service be determined.
- 10.2.2.4 That support and training be provided to MHS Helpline staff to ensure the level of specialist skill required for working within a triage service and a consistent quality of service.
- 10.2.2.5 That strategies be developed to improve reliability and appropriateness of data generated by the TRIO Database.
- 10.2.2.6 That a marketing strategy be implemented to market MHS Helpline with a particular focus on the North and North West and service providers outside of MHS.

10.2.3 Maximising Recovery Panels (MRPs)

- 10.2.3.1 A further consideration of the role, function and operation of MRPs be undertaken, with a particular focus on the rationale underpinning the referral process, time frames, capacity for consumer informed care, access to services, panel representation and involvement of case managers and other key stakeholders.

10.3 Strategic Priority 2 – Participation and Partnerships

10.3.1 Consumer and Carer Participation

- 10.3.1.1 That a consumer and carer participation framework, which includes consideration of the community mental health sector, be systematically implemented throughout MHS.
- 10.3.1.2 That the model of consumer and carer participation as determined by the current review of consumer and carer participation be considered for adoption within MHS and be resourced appropriately.

10.3.2 Family Sensitive Practice

- 10.3.2.1 That MHS take action to ensure family sensitive practice is embedded systematically as part of the service delivery model for MHS.
- 10.3.2.2 That MHS State Office provide clarifying policy in regard to privacy legislation in order to facilitate family and carer inclusion where clinically appropriate.

10.3.3 Partnerships

- 10.3.3.1 That strategies be developed which enable a more strategic interface with community sector organisations, as well as considering an approach which encourages the development of partnerships and collaboration and recognises that collaboration requires dedicated time and resources.
- 10.3.3.2 That MHS develop and implement processes for ensuring awareness of services, support groups and activities relevant to the mental health sector and make this information available to the community.
- 10.3.3.3 That MHS considers approaches to formalise relationships with stakeholders using vehicles such as Memorandums of Understanding (MOUs) if appropriate.
- 10.3.3.4 That MHS consider resourcing to the non government mental health sector.

10.4 Strategic Priority 3 - Governance and Leadership

- 10.4.1 That MHS implement a clinical governance structure, for Mental Health Services, which provides effective clinical governance and is appropriately resourced.
- 10.4.2 That MHS develop a plan for implementation and resourcing of clinical and professional supervision.
- 10.4.3 That MHS introduces a systematic approach to performance development and provides appropriate support to managers to ensure this occurs.

10.5 Strategic Priority 4 - Workforce Development

- 10.5.1 That MHS develop an appropriate process for determination of training priorities and consideration of requests for training and/or professional development. This should include a needs assessment, linked to the professional development and/or training needs of Mental Health Services' staff.
- 10.5.2 That MHS assess the level of resourcing required to provide the training and professional development as determined.
- 10.5.3 That MHS develop and implement recruitment and retention and workforce planning strategies which support the model of care.

10.6 Strategic Priority 5 - Quality and Safety

- 10.6.1 That MHS develop and implement an appropriate clinical governance framework, including the revitalisation of the previous clinical reference groups or similar forums.
- 10.6.2 That, as a matter of urgency, MHS develop statewide policies and procedures which support the model of care and consider national, state and local requirements, mental health standards and legal requirements.
- 10.6.3 That MHS develop and implement systematic review and audit of policies and procedures and ensure current policies and procedures are readily available to all staff.
- 10.6.4 That MHS implement a program of systematic accreditation and review of Mental Health Services against relevant health care standards.
- 10.6.5 That MHS identify dedicated resources to enable implementation of recommendations in relation to Strategic Priority 5 – Quality and Safety.

10.7 Strategic Priority 6 - Sustainable Resources

- 10.7.1 That MHS develop an understanding of the resourcing implications of meeting the mental health needs of the community into the future and factor this into its formal planning.
- 10.7.2 That MHS develop and implement a population based planning model which considers socio economic factors, acuity and changes to demographics such as ageing populations.