BETTER INTEGRATION of MENTAL HEALTH SERVICES in SOUTHERN TASMANIA

Mental Health Integration Taskforce Report and Recommendations

April 2019

Mental Health, Alcohol and Drug Directorate
Department of Health

Tasmanian Government

This Report has been prepared by the Mental Health Integration Taskforce (the Taskforce) to provide the Secretary of the Department of Health with recommendations on the integration of mental health services in Southern Tasmania.

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The observations, findings and recommendations set out in this Report are the observations, findings and recommendations of the Taskforce and may not reflect the views of the Crown in right of Tasmania.

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To the people with lived expertise of mental illness, your contributions were central to the considerations of the Taskforce. The Taskforce wants to thank the invaluable support of staff of the Mental Health, Alcohol and Drug Directorate, Statewide Mental Health Services and the Office of the Chief Psychiatrist in reviewing and finalising this report. A special thanks goes to Jeremy Harbottle, Anna Mayo, Cat Schofield, Bec Thomas and Dr Richard Benjamin amongst others in reviewing the Report's contents.

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Notes on Language Used in this Document

This document does not refer to patients. Instead, it refers to consumers, people with lived experience of mental illness or people with expertise of mental illness. This terminology reflects a growing recognition that people with mental illness are best placed to make decisions about their lives.

This document also recognises that some people who access the Tasmanian mental health system do so when they are in suicidal distress and may not have mental illness.

Throughout the document:

- *Rethink Mental Health – Better Mental Health and Wellbeing – A Long-Term Plan for Mental Health in Tasmania 2015 – 25* is referred to as *Rethink*.
- The Mental Health Integration Taskforce is referred to as the Taskforce.
- This document is referred as the Report.
- The Tasmanian Department of Health is referred to as DoH.
- The Tasmanian Health Service is referred to as the THS.
- Statewide and Mental Health Services is referred to as SMHS.
- The Taskforce's findings are numbered sequentially using Roman Numerals (i, ii, iii, iv, etc).
- The Taskforce's recommendations are numbered sequentially using Arabic Numerals (1, 2, 3, 4, etc).

There is no agreed to definition of Integration in common use in Australia. Consequently, this Report has developed two definitions of integration; one from the perspective of people who live with mental illness and the other from the perspective of people who provide services or integrate care and support. This is explained in further detail in the body of this Report on pages 22-24. Furthermore, vertical integration is used to refer to the way the range of clinical services are integrated, whilst horizontal integration is used to refer to the way in which the range of all other supports are integrated.

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Message from the Taskforce Chair

In March 2018, the Tasmanian Government outlined several Election Commitments related to Mental Health. This included the establishment of a Taskforce to consider the best approaches to achieving integration of Mental Health Services in Southern Tasmania.

The Taskforce explored world's best practice for integration of mental health services, as well as best practice examples in Australia, and considered the suitability of their adoption in Tasmania.

Just over three years ago, the Tasmanian Government committed to developing an integrated mental health service as part of *Rethink Mental Health - Better Mental Health and Wellbeing – A Long Term Plan for Mental Health in Tasmania 2015-25* (*Rethink*). The Taskforce noted slow progress in achieving this commitment, at least in Southern Tasmania, and considered reasons for this as well as how obstacles to integration could be removed.

The Taskforce was, at times, concerned about the magnitude of the journey from the current system to one of best practice integration. Despite this the Taskforce shared a sense of optimism about the opportunity available to achieve change. The Taskforce was also acutely aware of the expectation from those with lived experience of mental illness that the sector will make this change and of the responsibility incumbent on the system to do so.

Notwithstanding this optimism, the undertaking required to implement the Taskforce's recommendations will represent one of the largest paradigm-shifts in Tasmanian mental health reform and will require a dedicated implementation team working over a period of at least 18 months.

The reform should aim to achieve the Institute of Healthcare Improvement's Triple Aim for Populations:

- enhancing the experience and outcomes for consumers;
- improving the health of the population, and
- reducing per capita cost of care[1].

The commitment of people with lived expertise of mental illness, professional bodies, industrial bodies, senior and middle levels of management within the THS, and all staff of SMHS is fundamental to this transformation.

To be successful in achieving integration, the THS will need to address some key business processes including its models of care, consumer pathways, staffing profiles, human resource management, clinical information systems, policies, procedures, and the way in which the mental health stream articulates with all other parts of the health system.

The reform will require re-consideration of every aspect of service delivery. It will require new models of care, embracing new ways of thinking, a new culture of working and a clear process for managing change. It is not a reform that can be undertaken from the "top down", rather it will require all staff and every component of the system to be involved and an acknowledgement that the

[1] More information about the Triple Aim Initiative can be found here: www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

system will be focussed on needs of consumers, their families and carers rather than on the needs of the service provider. It requires leadership but also "bottom up" support from all those involved.

Patience will be needed throughout the process and leadership will need to have in mind the reality that integration is difficult and many mental health systems with the best intentions have not achieved the intended level of integration even after many years. Leutz 'Laws' (explained later in this document) should be forefront in considering the critical factors that underpin successful integration.

Ultimately no part of the current mental health service will be unaffected.

It was a privilege to have been asked to Chair the Taskforce and lead the process that undertook this important work. I look forward to working with all stakeholders to deliver this important reform.

Dr Aaron Groves

Taskforce Chair

Chief Civil Psychiatrist and Chief Forensic Psychiatrist

2 April 2019

Executive Summary

Between March 2018 and March 2019, the Mental Health Integration Taskforce considered how mental health care should best be delivered to people in Southern Tasmania. The process involved consideration of a range of national and international reforms, initiatives and evaluations, key strategic planning processes and, importantly, the wisdom of those who have lived experience within the mental health system in Southern Tasmania, their family and carers.

These deliberations led the Taskforce to consider integration in vertical and horizontal dimensions, reflective of the complex interactions that occur within any mental health system and within other human service delivery systems and representing a useful framework for how best to reform the service system.

A summary of the Taskforce's recommendations follows.

Regarding Vertical Integration

The Taskforce recommended that:

1. SMHS should re-consider how it provides clinical services to develop a community mental health system in which each of the current services see themselves as an important, if not vital, part of a more distributed system of care, rather, than as a stand-alone service.
2. SMHS should reconsider the current boundaries of its catchment areas in Southern Tasmania and determine how to realign its resources so that there is a more equitable approach between catchment teams.
3. SMHS should develop new, consistent models of care for each of the four mental health programs within the service.
4. SMHS undertakes a review of the relationship between mental health services and alcohol and drug services to get a fuller appreciation of the difficulties between these two sectors.
5. In line with the commitment under *The Fifth National Mental Health and Suicide Prevention Plan* (the *Fifth Plan)* to undertake planning using the *National Mental Health Service Planning Framework* (NMHSPF), the DoH and THS need to address the fact that that the resources devoted to public mental health services are out of balance compared to the optimal distribution outlined in the NMHSPF.
6. SMHS and the Royal Hobart Hospital (RHH) need to agree to a governance model that involves cooperation and working together. This should include considering including SMHS on the RHH Executive.
7. SMHS needs to review how it provides clinical services, considering the services that people need to access urgently.
8. SMHS and Primary Health Tasmania (PHT) together with all parts of the primary mental health care system, notably the Tasmanian Branch of the Royal Australian College of General Practitioners, develop a better system of collaboration between public mental health services and primary care.

9. SMHS redefines how clinical services are provided within the community mental health system. This process should involve considering developing mental health nurse practitioner roles, enabling all health professionals to work to full scope and the role of peer workers.

10. SMHS should redevelop its model of care for sub-acute and non-acute inpatient services taking into account the impact of the National Disability Insurance Scheme (NDIS) once it is fully implemented as well as the outputs from the *Fifth Plan*.

11. SMHS should develop a clear plan for how it will better address the physical health needs of people who access the public mental health system.

12. The DoH and SMHS should urgently consider the need for a better mental health clinical information system that meets the needs of supporting vertical integration.

Regarding Horizontal Integration

13. The DoH and the THS adopt a new service element as a central, new feature of the community mental health system; namely, a 24-hour integrated service hub that consists of a range of collocated social services, disability support services, peer-operated services and clinical services, built around ensuring the recovery concept and supported by sub-acute residential services.

14. The Tasmanian Government considers the adoption of this service element within the current election commitments for the redeveloped Peacock Centre and the sub-acute services at St Johns Park.

15. The DoH, together with the Mental Health Council of Tasmania (MHCT), undertake a project to explore the best way of achieving greater integration of the full range of disability and social services that may need to be accessed by a person as part of their full participation in their community.

16. The DoH develops an approach that would allow the ability to have flexible funding through the community-managed sector in Tasmania that would support the provision of services that promote greater horizontal integration, either at the integration hubs or in other parts of the community mental health system.

17. The DoH works with Flourish Mental Health Action In Our Hands Inc. (Flourish), Mental Health Carers Tasmania (MHCTas), the MHCT and the SMHS to develop a model to trial the transferability of the Recovery College concept as an element within the integration hubs.

Regarding Implementation

18. That the Tasmanian Government set a timeframe for the adoption of a fully integrated approach within the Tasmanian mental health service. It is recommended that this date be 1 January 2021.

19. That the DoH note the significant undertaking to move to an integrated service system and agree to the development of an endorsed program structure to oversee the process of implementation (henceforth referred to as the Reform Program). The Reform Program should identify, at the very least, an overall Executive Sponsor who is accountable for the program, the resources available to undertake this reform process and the program deliverables, proposed outcomes, communication and change management processes.

20. The THS will need to identify a range of workforce reforms that support this process. This will include how all clinical staff can demonstrate that they are competent in the 16 values and attitudes contained within Standard 9 (Integration and Partnership) of the updated *National Practice Standards for the Mental Health Workforce 2013*[2]. This Standard, together with Standard 9 (Integration) of the *National Standards for Mental Health Services 2010*[3] are key documents that should set out the expectations for an integrated system of mental health care.

    Furthermore, the THS should consider the degree to which the National Framework for Recovery-Oriented Mental Health Services[4], the "triangle of care" concept and the principles of Trauma-Informed Care and Practice, are known and adopted by all clinical staff. These three frameworks are considered fundamental to successful integration. SMHS will need to determine what investment is needed to ensure staff have competency with these approaches.

21. It is recommended that the recommendations within this report are used as the basis for exploring whether they are equally applicable in the North and North-west regions of Tasmania. It is the Taskforce's recommendation that they apply.

The recommendations reflect both the discussions and the intent of the Taskforce and represent a consensus view of how lasting system change that delivers the best outcome for those who come into contact with the system, can be achieved.

[2] State of Victoria, Department of Health, 2013, *National Practice Standards for the Mental Health Workforce 2013*.
[3] Commonwealth of Australia, 2010, *National Standards for Mental Health Services 2010.*
[4] The Framework was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) on 12 July 2013 and formally launched by the Chair of AHMAC at the Mental Health Services Conference (TheMHS) on 21 August 2013. The Framework is presented in two companion documents, both of which can be found here: www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

Chapter 1 Policy Context

International Context

The concept of integration is a dominant paradigm in other countries with developed economies. This is evidenced through the development of a range of supporting initiatives including several academic journals solely devoted to integration (such as the *Journal of Integrated Care: Practical evidence for service improvement*[5] and the *International Journal of Integrated Care*[6]), major government programs in the United States and United Kingdom that have explored the outcomes of better integration, and even multi-national collaboration aimed at better integration such as the European Union's *Project INTEGRATE*[7].

Integration is included as a key element of the national mental health plans of many countries with similar health systems to Australia, namely England[8], Scotland[9], Ireland[10] and Canada[11], and in 2018 the New Zealand Government's inquiry into the country's mental health system outlined the need for a much more integrated mental health system in multiple areas[12].

Throughout Europe, an approach to integration has seen a fundamental reform of mental health and this is especially the case in Spain and Italy.

Perhaps the most often cited example of the benefits of a mature, stable integrated system of mental health services is that of Trieste, Italy. This service, which has been recognised as a World Health Organization Collaborating Centre, has been the site of research that has firmly established the effectiveness and sustainability of a properly resourced, integrated mental health system, particularly when focussed on recovery, social inclusion and the respect of human rights[13].

The mental health system in Trieste has undertaken a process of total deinstitutionalisation and progressive transformation to the community to achieve:

- a fully community-based service with multiple community options for community care, such as group homes, day centres, social clubs and places where a range of different social services are available
- a low threshold for entry, and no barriers to access
- mental health issues are recognised as integral within the systems that apply to social inclusion such as housing, disability, welfare and general health care
- a focus on respect for the autonomy of the person, return of citizenship and the centrality of human rights instead of the paradigm of illness, and

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[5] Accessible online here: www.emerald.com/insight/publication/issn/1476-9018
[6] Accessible online here: https://www.ijic.org/
[7] Project INTEGRATE aims to gain valuable insights into the leadership, management and delivery of integrated care to support European care systems to respond to the challenges of ageing populations and the risk of people living with long-term chronic conditions. For more information, visit www.projectintegrate.eu.com
[8] The Mental Health Taskforce, 2016, *The Five Year Forward View for Mental Health.*
[9] Scottish Government, March 2017, *Mental Health Strategy 2017-2027.*
[10] Government of Ireland, 2006, *A Vision for Change - Mental Health and Suicide Prevention*.
[11] Mental Health Commission of Canada, 2012, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada.*
[12] Government Inquiry into Mental Health and Addiction, November 2018, *He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction*.
[13] Bennett, D. H., Spring-Summer 1985, "The Changing Pattern of Mental Health Care in Trieste", *International Journal of Mental Health,* Vol.14, No.1/2, pp 70-92.

- incorporation and inclusion of a diverse range of stakeholders.

The system of integration in Trieste is now worldrenowned and has been the subject of widespread description in literature, including a report from the 2006 Australian Senate Select Committee on Mental Health, chaired by Senator Lynn Allison[14]. The Trieste model is now established in several countries and has been supported by the development of formal collaboration between the WHO Collaboration centre in Trieste and these countries.

Integration has also been demonstrated internationally and more recently in Australia through adoption of the 'Recovery College' concept. Developed out of the Recovery Movement, the Recovery College concept is founded on the principle that every person with a mental illness has a right to pursue a life that is satisfying and that provides meaning, purpose and hope[15].

Recovery Colleges provide an educational approach to improving mental health as opposed to a clinical one. Recovery Colleges adopt a co-design approach to the delivery of services and focus on strengths, rather than problems and illness. Recovery Colleges, of which there are more than 40 in operation internationally, are found across a range of countries, including the UK, USA, Italy, Australia and Japan.

National Context

Providing a more integrated system for delivery of mental health services has been a goal of national health planning since the National Mental Health Strategy was agreed to by Australian Health Ministers in 1992[16]. Integration has been a feature of National Mental Health Plans since the First Plan was released in 1993 and is a pivotal theme underpinning the *Fifth National Mental Health and Suicide Prevention Plan* (the *Fifth Plan*), which was endorsed by the Council of Australian Governments Health Council in August 2017[17].

Integration is recognised in the *Fifth Plan* as a key priority area. This priority is interlinked with all other priority areas of the plan and is recognised as the key action agreed by governments for ensuring that consumers and carers are at the centre of the way in which services are planned and delivered.

As noted above and explored further below, while integration has been a feature of all previous National Mental Health Plans, achieving integration has remained elusive. There are many reasons for this, including the difficulty sometimes experienced in achieving cooperation between multiple levels of government and across portfolios.

The Fifth Plan makes the following observations:

> *The National Mental Health Commission's 2014 Review of Mental Health Programmes and Services concluded that all mental health services are fragmented and delivered within a complex system that involves multiple providers and siloed funding streams, with the different parts of the service system often operating in isolation of each other and people having a poor experience of care and unmet*

[14] Commonwealth of Australia, 2006, *A national approach to mental health – from crisis to community: Final Report*.
[15] More information about the Recovery Model and Recovery Colleges can be found here: imroc.org/
[16] The strategy was endorsed in April 1992 by the then Australian Health Ministers' Conference as a framework to guide mental health reform. It includes a national mental health policy, national mental health plan and mental health statement of rights and responsibilities. More information can be found here: https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-strat
[17] Commonwealth of Australia as represented by the Department of Health, 2017, *The Fifth National Mental Health and Suicide Prevention Plan*.

need. [The Review] highlighted service gaps, inefficiencies, duplication and poor planning and coordination, compounded by a lack of clarity of roles and responsibilities by governments. It suggested that both levels of government too often make decisions about programs and services without proper engagement, planning and co-design, and fail to address the critical issue of system design. It called for a better integrated, person-centred service system and identified opportunities to better integrate services.

The *Fifth Plan* also observes that for consumers and carers, a lack of integration and agreement on care pathways and service entry thresholds creates frustration and leads to poor treatment continuity, difficulty in maintaining treatment, poorer treatment outcomes and leads to a loss of faith in the treatment system.

In the context of the *Fifth Plan*, integration is concerned with building relationships between organisations that are seeking similar aims to improve the outcomes and experiences of consumers and carers. Integration can be implemented at different levels, but integration at any level can deliver better experiences and outcomes for consumers and carers.

It is a requirement under the *Fifth National Mental Health and Suicide Prevention Plan Implementation Plan*[18] for Tasmania, along with other States and Territories, to develop an integrated regional plan for the delivery of mental health services that outlines not only the role of all providers but also how they could work in a more collaborative manner.

Tasmanian Context

The Tasmanian Government launched *Rethink* in 2015 following an extensive stakeholder consultation process spanning nearly six months. *Rethink* delivered on the Government's commitment to develop an integrated mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help.

Rethink Reform Directions 4 and 5 relate to integration and provide as follows:

Reform Direction 4

1. *An integrated Tasmanian mental health system will incorporate a person-centred, whole of life, whole of person approach that promotes recovery and wellness. It will recognise that people living with mental illness and their families and carers can and do recover and it will also recognise the unique needs of individuals including the physical, social, emotional, cultural and spiritual aspects of their life. It will ensure that design and delivery of programs and services are underpinned by the principle that each person brings with them their own circumstances and life experiences. It will listen to people with a lived experience together with their families and carers about what helps and what interferes with their recovery. It will recognise the many ways that families and carers contribute to a person's recovery. It will provide flexible programs and services to support individuals to improve their mental health. More broadly it will coordinate support and ensure continuity from one service or setting to another.*
2. *It is also essential that public mental health services, community sector organisations, primary health and private providers create supportive environments for people to recover. Recovery*

[18] Commonwealth of Australia as represented by the Department of Health, 2017, *The Fifth National Mental Health and Suicide Prevention Plan Implementation Plan*.

orientation can and must be embedded into the mental health system, informing every aspect of service delivery.

Reform Direction 5

1. *Our Goal is to re-orientate the Tasmanian mental health system to increase community support and reduce the reliance on acute, hospital based mental health services.*

2. *The current mental health service system in Tasmania relies heavily on public mental health services and in particular inpatient services. There continues to be significant demand for these services which can make immediate access difficult. Greater access to community support is the key to reducing the level of demand on these services and to positively influencing the recovery of people with mental illness.*

Rethink brings together action to strengthen mental health promotion, prevention and early intervention, action to improve care and support for people with mental illness, their families and carers and sets a path for integrating Tasmania's mental health system. It includes short, medium and long-term actions to achieve this vision over a ten-year period.

The Tasmanian Government's commitment to suicide prevention reform is outlined in *The Tasmanian Suicide Prevention Strategy (2016-2020): Working Together to Prevent Suicide*[19] and its companion documents the *Youth Suicide Prevention Plan for Tasmania (2016-2020)*[20] and the *Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020)*[21]. As with *Rethink*, these strategies call for a much closer collaboration, partnership and integration of services, communities and a range of suicide prevention approaches with health service providers such as General Practitioners (GPs) and the specialist health system in Tasmania.

Despite a clear commitment to change as expressed in these documents, it became apparent by late 2017 that not enough progress had been made towards integration. Recent focus has been on responding to increased mental health presentations to the Royal Hobart Hospital (RHH) Emergency Department, bed block and reduced numbers of acute mental health inpatient beds.

The State Government made a series of commitments in 2018 to assist with implementation of *Rethink* as follows:

- A commitment to invest $104 million in mental health care over a six-year period
- A commitment to build new facilities and employ staff to provide new mental health beds to support the RHH (Peacock Centre Redevelopment, St Johns Park greenfield development and Mental Health Hospital in the Home (MHHITH))
- A commitment to employ over 125 additional frontline staff
- A commitment to provide a $3.3 million boost to the community sector to support better health in our communities
    - Housing and Accommodation Support Initiative Trial

[19] Department of Health and Human Services, Mental Health, Alcohol and Drug Directorate, March 2016, *The Tasmanian Suicide Prevention Strategy (2016 – 2020): Working Together to Prevent Suicide*.
[20] Department of Health and Human Services, Mental Health, Alcohol and Drug Directorate, March 2016, *Youth Suicide Prevention Plan for Tasmania (2016 – 2020).*
[21] Department of Health and Human Services, Mental Health, Alcohol and Drug Directorate, March 2016, *Suicide Prevention Workforce Development and Training Plan for Tasmania (2016 – 2020).*

- Mental Health Peer-Workforce Strategy
- Eating Disorders Peer Workers Partnership
- Rural Alive and Well

- A commitment of $6 million over three years for 30 additional community-based drug and alcohol rehabilitation beds[22].

The Taskforce was established within this context to:

- Provide expert advice on the best use of the new mental health beds to the benefit of Tasmanian consumers, including how best to deliver services across the spectrum of mental health care from community facilities, inpatient units and Emergency Departments to ensure that Tasmanians get the right care, at the right place, in the right time, and
- Reinvigorate the commitments made through *Rethink* to develop an integrated mental health system with a focus on Southern Tasmania.

Chapter 2 Service Delivery Context

Like acute health services more broadly, funding for mental health services in Tasmania is provided by both the Tasmanian and Australian Governments. Services are delivered in a range of settings, from primary and community care through to acute hospital care.

The Tasmanian Government provides funding for public sector services and sets legislative, regulatory and policy frameworks for mental health service delivery.

Public sector mental health services provide specialised care for people with mental illness, particularly focussed on those people who may have the more severe levels of illness. These include admitted inpatient services delivered in hospitals and services delivered in community mental health settings.

Public mental health services are provided across Tasmania through the Tasmanian Health Service. Services include:

- 24-hour acute inpatient units located at three public hospitals (the RHH, the Launceston General Hospital and the North West Regional Hospital – Burnie)
- a 24-hour older persons acute/sub-acute inpatient unit located in the south providing services to people across the state (the Roy Fagan Centre)
- a 24-hour step up/step down facility located in the south (Mistral Place)
- 24-hour specialist extended treatment units located in the south and providing services to people across the state (Millbrook Rise Centre and Tolosa Street)
- child and adolescent, older persons and adult community mental health clinical services that operate throughout the state
- adult community mental health teams that provide crisis, assessment, treatment and triage services
- a 24/7 statewide helpline and triage service – the Mental Health Services Helpline
- forensic mental health services that provide community and inpatient care for people with a mental illness who are involved with, or at risk of involvement with, the justice system (including the Wilfred Lopes Centre).

In October 2018, the Government also announced the establishment of a Mental Health Hospital in the Home (MHHITH) service. The service, which commenced operation in March 2019, consists of a 12-bed service and employs up to 18 staff across a range of disciplines, as well as peer workers. The service is intended to provide treatment for people in an acute phase of mental illness, who are assessed as being able to receive this service in their own home. It provides intensive hospital level treatment and operates with extended hours, seven days a week.

The Tasmanian Government also provides substantial funding to community-managed organisations for a range of activity including:

- psychosocial support services;
- individual packages of care;

- residential rehabilitation;
- community-based recovery and rehabilitation;
- peer support groups;
- prevention and brief intervention services; and
- advocacy and peak body representation for consumers, carers and service providers.

The Australian Government provides Medicare and grant-based funding and policy direction for the delivery of primary mental health care services by GPs, private psychologists, nurses and other allied health professionals, as well as providing core funding to Aboriginal Community Controlled Health Services.

The Australian Government also provides funding for a range of specialist mental health services including:

- psychological disability support through the National Disability Insurance Scheme (NDIS);
- funding for the aged care sector including funding for mental health programs for older Australians in residential aged care facilities;
- funding to subsidise medicines through the Pharmaceutical Benefits Scheme (PBS);
- funding for Headspace centres;
- funding for the National Suicide Prevention Trial site in Northern Tasmania;
- national projects such as the National Education Initiative; and
- projects that are provided by multiple national organisations such as Beyond Blue.

The Australian Government also has a central role for other components of the mental health system through funding national research and telephone-based and digital service delivery initiatives and building the tertiary education sector.

In Tasmania, the community-managed sector generally operates on a not-for-profit basis and is funded by both the Tasmanian and Australian Governments. It includes both large and small organisations, some with statewide coverage and many different programs, and some that operate in only one region. These services often have strong connections with local communities and can engage those communities to deliver better social outcomes for consumers and carers.

The private health sector provides professional fee-based services in both inpatient and office-based settings. These services include primary mental health care, acute specialist management, rehabilitation, psychological interventions and other allied health-based supports. Private sector professionals and organisations are substantial contributors to overall service delivery in mental health with their funding provided by a mix of individual payments and Australian Government rebates.

In Southern Tasmania, the major providers of private inpatient mental health care are the Hobart Clinic and St Helen's Private Hospital.

Who Does the Tasmanian Mental Health Service Support?

The Tasmanian public mental health service is primarily designed to provide a range of clinical services to people living with the most severe forms of mental illness. It is generally accepted from Australia's comprehensive epidemiology of mental illness that this represents about three per cent of all Tasmanians, although this rate varies across the life span.

By contrast, the Australian Government, through its programs, primarily focuses on funding services for those Tasmanians with mild to moderate levels of mental illness in need of treatment. This amounts to an additional estimated eight per cent of Tasmanians, most of whom will access services through their GP[23].

Thus, the mental health system in Tasmania, funded by two levels of government, is required to work in partnership to provide a complex array of services, inclusive of the community mental health sector, general practice, private specialists and facilities, inpatient units of public hospitals, specialised community clinical mental health centres and, increasingly, a range of mobile and digital mental health services, to approximately 11 per cent of the population at any one point in time.

Who is the Workforce?

In Southern Tasmania, at the time of the Taskforce's deliberation, the public mental health workforce consisted of 200.28 Full-Time Equivalent (FTE) staff working in a range of inpatient settings and 110.93 FTE staff working in community mental health clinical settings.

An analysis of recruitment practices shows long-standing positions that have been difficult to recruit to, leading to increased overtime and consistent use of locum staff to ensure the provision of critical services. This is not only costly; the lack of consistency also contributes to the lack of integration. This issue is not restricted to Tasmania, with all States and Territories experiencing significant difficulties in both training and recruiting mental health staff. This represents one of the greatest challenges to both reforming the current system and meeting an increasing demand for mental health services.

[23] University of Queensland, *National Mental Health Service Planning Framework AUS V2.1*, available from www.nmhspf.org.au

Chapter 3 The Taskforce Process

Who is the Taskforce?

The Taskforce consisted of 51 people with a range of expertise including:

- people with lived experience of mental illness;
- peak mental health community sector organisations ;
- professional bodies;
- industrial organisations;
- senior clinicians from in-patient and community settings;
- SMHS Senior Managers and Executives;
- representatives from Adult, Older Adult, Child and Adolescent, Perinatal, Forensic and Alcohol and Drug Service programs;
- representatives from the RHH Emergency Department; and
- GPs.

A full list of members is extracted in Chapter 7 at Appendix 1.

What was the Taskforce asked to do?

As outlined in Chapter 1, the Taskforce was formed to provide advice on:

- improving integration in mental health services in Southern Tasmania;
- how services can best be delivered across the spectrum of mental health care – from community facilities, inpatient units and the RHH Emergency Department – to ensure Tasmanians get the right care, at the right place, in the right time; and
- how the new mental health beds, committed to by the Government, should be utilised.

The Taskforce was also asked to provide a report to the Secretary, Department of Health containing recommendations on how to improve integration of mental health services in Southern Tasmania.

Methodology

An extensive list of resources was consulted to inform the content of the report. While not all resources are referenced in this report an extensive set of resources is available for consideration as part of implementing the Taskforce's recommendations.

The Taskforce did not call for submissions, relying on the process of formal and informal workshops and research to support its work. However, many members of the Taskforce wrote to the Taskforce Chair, in one case before the Taskforce's initial meeting. In addition, the Taskforce received written submissions from members of the Tasmanian community, many offering significant insight into the way integration could proceed. These submissions were read and formed part of the consideration of this report.

The Taskforce met six times from 1 May 2018 to 25 March 2019 to undertake its role. This included a series of half-day workshops outlined as follows:

Workshop 1:

Workshop 1 introduced the role of the Taskforce and sought feedback on key challenges and issues. The workshop considered what was working, what was not working, the barriers to better integration and the key factors to facilitate better integration.

Workshop 2:

Workshop 2 focussed on best practice models of mental health integration. Members considered the background, history, development and benefits of the Trieste mental health system and examples of attempts to bring elements of this system to some services in Australia.

The Taskforce noted the Trieste model with interest including the model's strengths and weaknesses. The Taskforce noted synergies between the concepts underpinning Trieste and mental health reforms in the 1980s[24] and subsequent health reforms as articulated through a range of documents, as follows:

- deinstitutionalisation (closing stand-alone psychiatric hospitals was included as part of the *First National Mental Health Plan*[25]);
- shifting resources from hospital settings to the community (a feature of all *National Mental Health Plans*);
- shifting the approach from health to a whole-of-government approach with mental health being the responsibility of all social sectors (as set out in the *National Action Plan for Mental Health 2006-2011*[26] and revised *National Mental Health Policy*[27]);
- adopting the Recovery Model (a feature of the *Fourth National Mental Health Plan*[28]);
- developing a National Mental Health Service Planning Framework (NMHSPF) (a requirement of the *Fourth National Mental Health Plan*[29]); and
- joint integrated Regional Planning (Priority 1 of the *Fifth Plan*[30]).

The Taskforce also considered the role of culture, family cohesion, the role of the church, the nature of the health system, the epidemiology of mental illness and substance use, and the role of informal care, and assessed these as critical to underpinning the model's success[31].

[24] Hoult J, August 1986, "Community Care of the Acutely Mentally Ill", *British Journal of Psychiatry*, 149: 137-144.
[25] Commonwealth of Australia, 1992, *First National Mental Health Plan (1993 – 1998).*
[26] Council of Australian Governments, 2006, *National Action Plan on Mental Health 2006-2011*.
[27] Commonwealth of Australia, 2009, *National Mental Health Policy 2008*.
[28] Commonwealth of Australia, 2009, *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009 – 2014.*
[29] Ibid.
[30] Commonwealth of Australia as represented by the Department of Health, 2017, *The Fifth National Mental Health and Suicide Prevention Plan Implementation Plan*.
[31] Informal care is provided by family, friends, neighbours, and concerned citizens, rather than by trained, licensed, certified health care professionals, or peer workers.

The workshop also focussed on analysis of the *National Mental Health Service Planning Framework*[32] as it applies to Southern Tasmania. This included a discussion of the optimal mix of services that should be provided in a balanced mental health system.

In Australia, there remains considerable disagreement about whether mental health services should be provided in community or hospital settings and whether the current challenges in mental health care is because of the shift from hospital to community care, without the appropriate balancing of resources.

Given the importance of this issue, the Taskforce considered the seminal review of systemic evidence conducted by Thornicroft and Tansella at the Institute of Psychiatry and Kings College London in 2004[33].

Thornicroft and Tansella's review found support for a balanced approach that includes comprehensive community services and hospital services, but also relies on good primary care, community residential care, assertive community treatment, early intervention, alternatives to acute inpatient care, support for employment and approaches to long term rehabilitation, as achieving the best service delivery model for high resource countries such as Australia.

The Taskforce noted the importance of this work in underpinning national mental health reform and subsequently guiding work to develop systems that have an optimal level and mix of mental health services to meet population demand.

The Taskforce noted the importance of the research in informing the joint integrated regional planning process currently underway.

The Taskforce considered the outcomes of the national mental health reform processes as they apply to Southern Tasmania and observed that, despite the existence of clear planning processes, a relative lack of community clinical resources remains.

Workshop 3:

Workshop 3 involved a detailed analysis of the opportunities and challenges associated with trying to apply a Trieste-like model in Tasmania.

The Taskforce's overall view was the Trieste model was transferrable to Tasmania and could be adopted in totality provided the Australian health and social service system, which varies greatly from that in Italy, was considered in the model's implementation.

Workshop 4:

Workshop 4 considered the history and development of Local Area Coordination (LAC) in Western Australia, its rollout in other parts of Australia and its adaptation to mental health in the United Kingdom and more broadly throughout Europe. The workshop also discussed the role of LAC-type models as central to a well-integrated mental health system.

This Workshop featured one session introduced by Eddie Bartnik, former Western Australian Mental Health Commissioner and Strategic Advisor to the National Disability Scheme on LAC.

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[32] Available from www.nmhspf.org.au

[33] Thornicroft, G. & Tansella, M., 2004, "Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systemic evidence", *British Journal of Psychiatry: The Journal of Mental Science,* Issue:185, pp.283-290.

Workshop 5:

Workshop 5 was devoted to the development of Service Integration Coordinators and Integrated Service Centres for Mental Health, considering Australian examples such as the Floresco Centre concept from Queensland.

This Workshop was introduced by Ivan Frkovic, Queensland Mental Health Commissioner and was jointly facilitated by Mr Frkovic and the Taskforce Chair.

Workshop 6:

Workforce 6 was devoted to a discussion of the Taskforce findings and recommendations. This Workshop reached a consensus view on the recommendations that form the basis for this report.

Additional Workshops

The Taskforce recognised at an early stage that it would be necessary to conduct a series of targeted Workshops to get a richer understanding of sectors' views on achieving better integration. Consequently, three additional Workshops were also held with key informants. One of the Workshops provided a forum for consumers and carers. Another of the Workshops was dedicated to seeking views from GPs and PHT, while the third Workshop was focused on the community-managed sector. These workshops focussed on:

- the scope of matters to be considered by the Taskforce;
- the complex and interconnected nature of health and social systems that are fundamental for ensuring a person's mental health and recovery required the Taskforce to clarify the boundaries of what it would consider; and
- stakeholders' perspectives on the current situation in the mental health sector, how better integration could be achieved, and the major priorities associated with this.

Scope

The Taskforce considered the following areas of interface as part of its work:

- acute inpatient and community mental health services;
- sub-acute and non-acute inpatient care, and community support and disability support;
- specialised mental health services, General Practice and primary care;
- Emergency Departments and other services for people in crisis;
- the interface between the Adult program and Infant, Child and Adolescent, Youth, Older Persons and Forensic streams;
- clinical services and disability support and social services;
- mental health care and general health care, alcohol and drug treatment services;
- private and public services; and
- the relationship with "pop up" and novel services that often have time-limited funding.

During the deliberations of the Taskforce the following areas were considered out of scope for consideration:

- matters specific to better integration of mental health services in Northern Tasmania and the North-west of Tasmania;
- matters more appropriately actioned through other election commitments;
- industrial matters;
- matters more appropriately actioned through Tasmania's implementation of the *Fifth Plan,* such as addressing stigma and discrimination and improving safety and quality in mental health care; and
- matters more appropriately actioned though *Rethink* where they are not primarily focussed on integration.

The delivery of universal programs that promote mental health and prevent mental illness are generally considered not to be the core business of public mental health services. Therefore, this important priority of *Rethink* was not considered to be in scope for the Taskforce. This is not to diminish the importance of mental health promotion and prevention - rather it is apparent there needs to be a better definition of how these services are provided within an integrated system.

Finally, it was important that for each of these aspects of the Taskforce's deliberations, the opinions of people with lived expertise were to be the central consideration in all aspects of how to achieve better integration. Thus, the Taskforce placed significant value on integration seen from the perspective of people who access the system and from the perspective of providers delivering the system.

Chapter 4 Understanding and Achieving Integration

While integration is referred to in *Rethink* and the *Fifth Plan*, the Taskforce considered that certain aspects of the concept of integration remain poorly understood in the Tasmanian mental health sector.

Integration has been described as "concerned with building relationship between organisations that are seeking similar aims to improve the outcomes and experiences of consumers and carers"[34].

Integration can also be understood in terms of its attributes. For example:

- People who access integrated systems find them seamless, smooth and easy to navigate. They do not have to tell their story multiple times or visit separate services;
- Integrated systems facilitate and support common, shared agreed recovery plans that pull together all aspects of a person's aspirations;
- Integrated systems acknowledge that consumers, their family and carers, and the service system are equal partners and comprise a "triangle of care";
- Integrated mental health systems are experienced by service providers as a single service, regardless of where they work, how they are funded and for whom they are employed;
- Integrated services are experienced as welcoming, appropriate and respectful. They encourage access and are non-discriminatory;
- Integrated systems are flexible and responsive. They understand that people's needs will fluctuate and that no one model will always be appropriate for all people;
- Integrated services are developmentally appropriate and fit for purpose. Child and Adolescent Mental Health Services (CAMHS) and paediatric services are linked with schools, child protection services and the youth sector, while Older Adult services are linked with geriatric medicine and aged care services. All services are linked to police and emergency services, employment services, housing support services, legal services, disability services and social services;
- Integrated services feature integration at multiple levels and require multiple different approaches including coordination, colocation, shared care and collaboration and integrated or unified care;
- The best models of integration allow for self-care and peer operated services and acknowledge that evidence is not equal by featuring models of care that are promising alongside models with strong, high quality evidence;
- Integrated mental health services are developed through a participatory design process involving consumers, carers and families who have an equal stake in this process (that is, they are co-designed);

[34] Commonwealth of Australia as represented by the Department of Health, 2017, *The Fifth National Mental Health and Suicide Prevention Plan,* page 18.

- Integrated mental health services aim to improve the health of the population and the experience of care, as well as reduce the per capital cost of care;
- People accessing integrated services are more satisfied and have a better of experience of care. They are more likely to adhere to medications and feel included[35]; and
- Critically integrated services are more cost effective than other models of service delivery[36].

Definition of Integration

The Taskforce proposes that Tasmania adopts two equally valid but distinct definitions of integration.

1. From the perspective of the consumer, integration means the follows:

   "My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes" (from the British Government's "My Care Plan").

2. From the perspective of those others involved in integration, the Taskforce proposes that a minor adaption of the definition of Kodner and Spreeuwenberg (found in England and Lester)[37] be used as the starting point for Tasmania's mental health system:

   "Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the care and care sector … to enhance quality of care and quality of life, consumer experience and system efficiency for people living with mental illness, their family and carers, that cuts across multiple services, providers and settings".

Furthermore, in understanding these definitions, Rhodes[38] placed importance on integrated ways of working as a method of overcoming the complexity associated with welfare care, and such ways of working are characterised by dynamic, flexible and evolving methods of working that rely on self-governing networks.

The 'Laws' of Integration

In 1999, Leutz (as he subsequently noted himself) had the audacity to describe what he referred to as the Five Laws of Integration[39]. These laws, even when revisited two decades later, are of fundamental interest.

The 'Laws' as originally described are as follows:

1. You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people;
2. Integration costs before it pays;
3. Your integration is my fragmentation;

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[35] Blount A, *The future of medical and mental health collaboration, Family Practice Volume 17 Issue 6: 574-575, 2000* and Social Exclusion Unit (UK), *Mental Health and Social Exclusion,* 2004

[36] Thornicroft, G. and Tansella, M., 1999, Routledge: London, *Common Mental Disorders in Primary Care*.

[37] England E & Lester H, *International Journal of Integrated Care*, 2005

[38] Rhodes RAW. 2000 *Transforming British Government.* London: Macmillan.

[39] Leutz W, 1999, "Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom", *The Milbank Quarterly,* 77: 77-110.

4. You can't integrate a square peg and a round hole; and

5. The one who integrates calls the tune.

Leutz subsequently described a sixth law, being that all integration is local[40].

Leutz' 'Laws' will be fundamental to how Tasmania moves toward implementing a better integrated system.

Vertical Integration

This report has proposed a definition for integration and described what is usually referred to as vertical integration.

Vertical integration refers to the bringing together of different levels of services within one system. In mental health services, vertical integration would see inpatient community-based and primary care clinical services provided alongside phone, online, digital and mobile clinical services.

Within the mental health context, vertical integration may be understood as the way in which the clinical components of a person's care and treatment are coordinated and provided. This encompasses care that is provided in acute and sub-acute inpatient settings; specialised community mental health services; primary health care; and general health services in the areas of Infant, Child and Adolescent Mental Health Services, Youth Mental Health Services, Adult Mental Health Services, Older Adult Mental Health Services, and for some consumers, Forensic Mental Health Services.

Horizontal Integration

Horizontal integration refers to the bringing together of a range of professions, service types and organisations that operate at similar levels in the provision of care. For mental health services, horizontal integration would see clinical care provided alongside disability support services, vocational assistance services, housing services, social care services, legal services, and others.

This report has proposed a definition for integration and described what is usually referred to as horizontal integration. For the purposes of this document, horizontal integration of mental health services refers to the way the clinical system links to the psychosocial and disability support sector, and other social systems.

[40] Leutz W, 2005, "Reflections on Integrating Medical and Social Care: Five Laws Revisited", *Journal of Integrated Care,* Vol. 13 Issue: 5, pp.3-12.

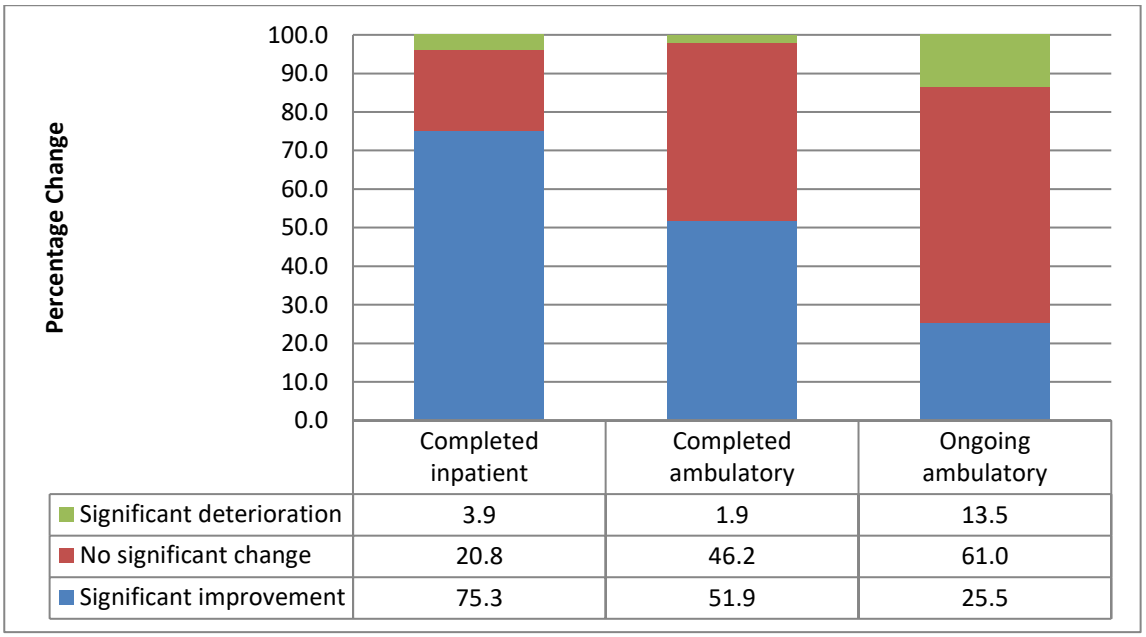
Chapter 5 Taskforce Findings and Recommendations

Vertical Integration

The Taskforce considered the Health of the Nation Outcome Scales (HoNOS) scores, feedback from the (Your Experience of Service)(YES) survey and other satisfaction surveys in evaluating the performance of mental health services in Southern Tasmania.

In Tasmania, the HoNOS is collected in all episodes of care in accordance with a National Protocol referred to as the National Outcomes Casemix Collection (NOCC). Analysis of this information shows half of all completed community episodes of care, and more than three quarters of inpatient episodes of care, show significant clinical improvement. Table 1 shows the most currently available outcomes of treatment for those who enter care.

Table 1: Percentage change in Tasmanian consumer's outcomes, 2016-17



	Completed inpatient	Completed ambulatory	Ongoing ambulatory
Significant deterioration	3.9	1.9	13.5
No significant change	20.8	46.2	61.0
Significant improvement	75.3	51.9	25.5

The YES survey is a nationally agreed measure of consumer experience of care. Tasmanian mental health services commenced surveys in October 2018 as part of a national approach to implementation. Preliminary analysis of survey responses shows an overall positive experience of service. More information is available in Chapter 7, Appendix 2.

The Taskforce also heard about a number of new and innovative projects that have commenced in recent months as services have attempted to adopt more contemporary approaches from elsewhere in Australia and overseas. The Taskforce observed that these efforts unfortunately took place in an environment where there was no clear approach to support such innovation and no process whereby funding could easily be diverted to support such initiatives. Consequently they are only available in some places.

The Taskforce's key findings with respect to vertical integration were as follows:

i. Services are provided by dedicated, hard-working and skilled staff;

ii. For a proportion of people, care is well provided and coordinated. People with such experiences value the care they receive, are happy with their experience and have positive clinical outcomes;

iii. The mental health system in Southern Tasmania was better integrated in the past than it is now. This change flows from a series of changes some years ago together with a dramatic increase in the demand for services'

iv. There is a perception that there has, at times, been a lack of investment in key components of the system which had led to the current situation whereby services are poorly integrated;

v. The Taskforce found there is a widespread culture of not working as a single system. This is manifest in several ways, such that it is reported that some key staff are often not available, others report being too busy or simply unavailable to respond to requests, others state they are unable to do what is requested, and others say they cannot help their colleagues. From the perspective of those staff, they see these responses to be because of excessive workloads and case burden, their perspective is that the whole system is "under siege", they feel unsupported, and increasingly being asked to do more and more with less. Community teams and inpatient teams did not feel there was any sense of stability and that for both, reform had been constant without a sense of their involvement and without apparent benefit or agreed vision of where the changes were leading;

vi. While staff referred to management inactivity as the source of issues experienced, it was unclear how management had been inactive and that this perception was more a reflection of the long-standing lack of capacity to address crises, rather than any failure on the part of service managers. Managers expressed confusion about roles and responsibilities;

vii. Many who work in the mental health sector seem unaware of the current vision and direction of mental health reform in Tasmania as outlined in *Rethink* and the current national mental health plan. While most staff are aware of the documents it was the Taskforce's view that few knew of the detail and even less had an awareness of who was responsible for implementation of these plans and what their role in reform might entail. Most are entirely focussed on getting through work each day and unable to set aside time to concentrate on how things could be done differently and whether a different approach would lead to a better overall service[41];

viii. Furthermore, on occasion, second tier managers felt unable to effectively undertake their roles, as they held the view the tools they needed and the information they required to effectively manage was not available or forthcoming. Many remained concerned that business systems and services within the THS did not adequately support them undertaking their roles. The Taskforce could find very little evidence that the THS has directly invested in building the leadership and management capabilities of the mental health system;

[41] Activities can be classified by urgency (Urgent or Not Urgent) and by importance (Important or Not Important). This creates four quadrants: Important and Urgent; Important but Not Urgent; Not Important but Urgent; Not Important and Not Urgent – see Czarto A, 2012, *The Four Quadrants of Time Management.*

ix. There is a lack of alignment of the processes between inpatient services and all other community clinical services. Specifically, it was felt that the system was "hospital-centric"; that is, the hospital was prioritised above both the needs of the consumer and of community services. This was considered the primary reason for the major disconnection between inpatient services and community-based services;

x. It was noted by several Taskforce members that, at times, the community mental health services were providing services to people they considered more acutely unwell than some of the people who were within the RHH mental health inpatient unit. In addition, it was found that there was no consistently articulated model of care for most aspects of the mental health service. As a result, the way the mental health inpatient unit, the mental health staff of the Emergency Department, the Helpline, community teams, case managers and subacute services operate, is as a set of disconnected silos with little evidence of integration, alignment or consideration of the relationships and interfaces with each other. Furthermore, it is uncommon for staff to move between these services and at times people have spent much of their career in one part of the service, never exposed to the way other parts operate;

xi. The current mental health clinical system was also noted to have stayed within an outdated paradigm. Specifically, while the Taskforce noted the importance of clinical leadership and responsibility with the importance of end-line clinical accountability, it was considered to have remained deeply aligned with a medical model at the expense of more contemporary models of clinical systems. This was manifest in several ways. Staff from non-medical professions often felt de-skilled, especially those with specific psychotherapy training, there was a lack of development of a mental health nurse practitioner role, a lack of clinical supervision models for non-medical professions, few systems to support novice practitioners, and at best a basic understanding of the potential value of the role of peer workers within clinical systems. In addition, most clinical services where provided within a dyad (that is one on one), rather than two groups of people who may get simultaneous benefit. It was also noted that more contemporary approaches favour the provision of clinical services in group settings where this is appropriate;

xii. The Taskforce noted that the role of peer workers was an emerging area in Tasmania but has had more than 15 years of development elsewhere in Australia;

xiii. Many reported problematic interfaces between the four predominant streams within SMHS. This was especially the case from the perspective of the adult team, in that its interface with CAMHS, Older Adult and the Forensic programs each held their own unique and currently unresolved difficulties. This is compounded by the additional interfaces with Alcohol and Drug Services and Correctional Primary Health Services.

xiv. Despite the abundant literature on life transitions and the problems these create, especially for those who live with mental illness, the Taskforce was unaware of any specific projects that aimed at ensuring SMHS programs either jointly or better manage these transitions from a systematic perspective. There was little evidence of formal arrangements, protocols, clinical partnerships, clinical collaborations, cooperative resource sharing between the programs that could promote greater understanding and the sense of a single unified system;

xv. Perhaps one of the greatest concerns expressed involved the relationship between the public mental health system and primary care. The Taskforce heard two different and conflicting perspectives. The first was that, despite their efforts, mental health services had great difficulty

engaging GPs in shared care and provision of better physical care or mental health care for people who live with either long-standing or the most severe forms of mental illness. It also heard that it was hard to find GPs who bulk billed mental health consumers, many of whom had difficulty making any out of pocket expenses. The second perspective was around the difficulty experienced by GPs in obtaining useful or timely advice. The public mental health system was often considered by the primary care sector to be unhelpful, unresponsive, a "black hole" that either gave no feedback or provided advice that was incorrect. Many GPs commented that the mental health system failed them;

xvi. Attempts to establish rapid assessment-only services to assist general practice with ongoing management (often referred to as "Item 291" clinics) have been attempted but have been difficult to fully establish in an enduring manner. While recently one community mental health team has established a dedicated GP nurse liaison role, this could only be achieved by diverting a clinical position that would otherwise have been providing case management. Consequently, general practice has had little recent experience of dedicated liaison and consultation support from public mental health services;

xvii. In addition, the Australian Government-funded initiative, formally known as the Mental Health Nurse Incentive Program, has not provided widespread support for primary care in Southern Tasmania, given the size of the demand they are confronted with. The Taskforce noted General Practice is the largest overall provider by volume of mental health services in Tasmania (as it is throughout Australia), albeit this mostly focussed on those with mild and moderate forms of mental illness. That there is no formalised partnership with public mental health service warrants attention. The Taskforce noted that several different joint initiatives between State-funded mental health programs and primary mental health care to get better models of collaboration and partnership have been tried elsewhere in Australia;

xviii. The Taskforce noted that the four leading causes of excess mortality for people with mental illness are:

- Cancer;
- cerebrovascular disease (stroke);
- cardiovascular disease (heart attack); and
- other circulatory or respiratory disease.

The Taskforce also noted that suicide in those people with a mental illness is, in fact, a less frequent cause of excess mortality. Despite this, the Taskforce noted that apart from a few isolated initiatives, SMHS had little awareness of programs that exist to address the most common physical health problems in those with mental illness. The role of dieticians, exercise physiologists/scientists and a range of other health professionals that improve physical health is under-recognised currently, despite being an agreed national mental health priority under the *Fifth Plan*;

xix. The Taskforce found low levels of integration between the clinical services provided by the Alcohol and Drug Service and the specialised mental health service. While the Taskforce acknowledged that there are differing and conflictual philosophies that underpin mental health services and alcohol and other drug service delivery worldwide, they remained of the view that there are better models built around the provision of clinical services to people with comorbidity than the model that applies in Tasmania;

xx. The Taskforce heard of concern about the way in which those with the most severe form of mental illness and greater psychosocial disability, are provided with clinical services. Tasmania is part of implementing one of Australia's most significant social policy reforms, namely the implementation of the NDIS. This represents an enormous opportunity for those who are eligible;

xxi. The Tasmanian mental health system must undergo a significant change to be fully realised. Most of those who access, or may in future access, the services of the Millbrook Rise Centre and Tolosa Street facilities will need to do so through a dramatically changed service model with shorter lengths of stay in inpatient care and with greater throughput. The only way to achieve this outcome is to quarantine provision of clinical services devoted to this extremely disadvantaged group and to shift resources to ensure their long-term reintegration into communities.

xxii. The Taskforce gave significant attention to how the different models of Crisis Assessment and Treatment Team (CATT) provision, triage, the dedicated Helpline, the role of Psychiatric Emergency Nurses (PENs), and the new Mental Health Hospital in the Home (MHHITH) Service will integrate. Many members raised doubts about how effectively these different parts of the service were linked and noted that the role of the Helpline and CATT as an important entry point to the community mental health service needs to be reconsidered. Another perspective was that the "front end" of the system was poorly designed and not linked, making it harder for consumers, carers and families to either access or navigate the system. Furthermore, there does not appear to have been a consistent adoption of approaches to triage within the system and the Taskforce heard that the system is primarily focussed on "keeping people out", rather than determining their needs and facilitating how this is best met, even when this may not be from the public mental health system. This was particularly considered a problem given the potential for the development of a parallel system within primary care that would only further add to inconsistencies in approach and create more confusion;

xxiii. The Taskforce heard the relationship between mainstream mental health services and other clinical services provided at the RHH was, in many cases, very poor. While there are some exceptions, including the close relationship between CAMHS and paediatric services and to some extent Older Adult Mental Health and Geriatric Medicine, this issue represents a major obstacle to proper vertical integration.

xxiv. A fundamental element of national mental health reform has been the need to provide acute mental health services on general hospital sites, so that people with mental illness have equity of access to the full range of health care available. Currently, the SMHS provides acute inpatient services at the RHH, a Consultation Liaison service throughout the hospital and specialist services to the Emergency Department. There is an urgent need to address the lack of a formal relationship between the RHH and the SMHS.

xxv. The Taskforce heard that, while the Australian Government had made substantial investment in a range of mental health and suicide prevention services, the public's knowledge about these services, together with few efforts to develop these services jointly (by either level of government), had the potential to lead to two entirely separate systems that focussed on people with mental illness and in suicidal distress, that could potentially cover the same priority groups, or worse, miss a consumer altogether;

xxvi. The Taskforce found several key systems that usually support vertical integration were not in place. The most critical of these was a single real-time clinical information system for mental health. Currently the mental health service in Southern Tasmania relies on paper-based community and inpatient files, the system's electronic medical record, the Digital Medical Record (DMR) and TrakCare (a digital system used in Forensic Mental Health Services). This means that real-time, consistent and comprehensive information is not readily available at any single point of care delivery. This contrasts with nearly all other mainland states that developed such systems under funding arrangements from the Australian Government under the first Mental Health Information Development Plan funding agreement, in the early part of this century. Consequently, Tasmania has a legacy of more than 15 years without a method of rapidly sharing the information needed to provide consumers with integrated clinical care. This shortcoming was considered by the Taskforce as the single most enabling non-human resource needed for achieving vertical integration;

xxvii. The Taskforce noted the commitment to rolling out the DMR in mental health services; however, it is noted this system fell well short of the functionality needed for an integrated system and is currently available in mainland states; and

xxviii. The Taskforce also recognises the current mental health system is dominated by several professional cultures and behaviours with reluctance on the part of some to participate in different ways of providing integrated services that deviate from the models in which they were originally trained. For some people who access the system there is also a reluctance to move away from the way in which they have accessed services in the past.

Recommendations

The Taskforce made the following recommendations:

1. SMHS should re-consider how it provides clinical services to develop a community mental health system in which each of the current services see themselves as an important, if not vital, part of a more distributed system of care, rather, than as a stand-alone service

   This is a fundamentally different approach from the approach that applies currently. Rather than detracting from the major function of providing high quality clinical care this approach acknowledges that the service exists as a vital part of a person's life, alongside other important players. Intrinsic to this reconsideration is recognition that the community mental health system becomes the primary part of the system that manages access to the system, flows through the system and transitions between the system and this occurs alongside the views of the consumer.

   Achieving this recommendation will require the role of acute inpatient services to be reconsidered. It is necessary for staff in acute inpatient settings to be more fundamentally aware of how the community mental health system operates, and to ensure that people are supported to return to their own homes at an earlier point of time. One important consideration is whether key staff should be appointed to undertake their role in both inpatient and community settings, such that they follow the person's care throughout an episode of care.

   The system should be designed to have greater consistency for those that are involved in a person's care. The approach should be designed to allow care to follow the person, as opposed to the person needing to navigate a complex disjointed system;

2. SMHS should reconsider the current boundaries of its catchment areas in Southern Tasmania and determine how to realign its resources so that there is a more equitable approach between catchment teams. This is to address the current situation where caseloads and case burden are not matched with resourcing levels;

3. SMHS should develop new, consistent models of care for each of the four mental health programs within the service. Of primary importance, this should be done jointly to get an agreed understanding of the boundaries and interfaces. This is particularly the case in trying to get commitment by all clinical staff to a single system of clinical care, as opposed to a set of discrete non-overlapping siloes;

4. SMHS undertakes a review of the relationship between mental health services and alcohol and drug services to get a fuller appreciation of the difficulties between these two sectors. This review should focus on the difficulties identified and the degree to which the current systems and their interface allow people with any degree of comorbidity to access care and treatment in a timely and appropriate manner. SMHS should consider whether an external reviewer with experience in the provision of services from both sectors should be involved to provide advice about how the two sectors provide better integrated clinical services;

5. In line with the commitment under the *Fifth Plan* to undertake planning using the NMHSPF, the DoH and the THS need to address that the resources devoted to public mental health services are out of balance compared to the optimal distribution outlined in the NMHSPF. In this regard, there is a current challenge to address the major shortfall in community clinical staffing levels across all mental health programs. Without addressing this it is unlikely any significant integration can be achieved;

6. SMHS and the RHH need to agree to a governance model that involves cooperation and working together. This should include considering including SMHS on the RHH executive. An agreement should be developed that outlines the nature of each service's roles and responsibilities and the resources that are made available by the THS to undertake these functions. The agreement should also address the provision of consultation-liaison services to the general hospital and commence the process of determining what is the nature of the service, inclusive of the number of beds, that will be provided in the Emergency Department, at the conclusion of the recently announced Stage 2 redevelopments at the RHH;

7. SMHS needs to review how it provides clinical services, considering the services that people need to access urgently. This will require a fundamental reconsideration of the role of the Helpline, CATT, Duty Officer roles, PENs and the MHHITH. As part of this review, SMHS should look to having one system of triage, assessment and crisis care across Southern Tasmania, which integrates the Helpline function and has a clear connection to both MHHITH and the Emergency Department. It is critical that barriers that currently exist because of different service models and inclusion criteria between different geographical teams are removed as a matter or priority. In reorganising these parts of the service, it is important that staff have an opportunity to work in various parts of this service to get competencies in all aspects of these roles;

8. SMHS and PHT together with all parts of the primary mental health care system, notably the Tasmanian Branch of the Royal Australian College of General Practitioners, develop a better system of collaboration between public mental health services and primary care. This should consider approaches that have been adopted in mainland Australian states, such as general

practice liaison nurses, "Item 291" clinics and better defining the role of general practice as a key component of a newly considered community mental health system. It is recommended that across Southern Tasmania there should exist a clear linkage between primary care providers and specialist clinical services built around the needs of the consumer. A key feature of this approach should include the development of a newly designed system of shared care in which both sectors have their concerns addressed. This is a major re-orientation that needs dedicated resources that ultimately should bring efficiencies, better outcomes, higher quality services and greater levels of improved consumer outcomes and satisfaction;

9. SMHS redefines how clinical services are provided within the community mental health system. This process should involve considering developing mental health nurse practitioner roles, enabling all health professionals to work to full scope and the role of peer workers. This model of care should enable an approach which allows clinical staff to use their full range of skills. This could be better reflected within a scope of practice that allows them to complement the current prevailing models of care. Consideration should also be given to group service provision, as a way of making more service available to more consumers;

10. SMHS should redevelop its model of care for sub-acute and non-acute inpatient services taking into account the impact of the NDIS once it is fully implemented, as well as the outputs from the Fifth Plan. This would see a fundamental shift of care from institutions to community settings with the preservation of funding to ensure enough clinical care is available in the future for people who have the most severe forms of mental illness and the highest levels of psychosocial disability;

11. SMHS should develop a clear plan for how it will better address the physical health needs of people who access the public mental health system. This should involve facilitation of better access to screening services and better management of cardio-metabolic risk and dual diagnosis; and

12. The DoH and SMHS should urgently consider the need for a better mental health clinical information system that meets the needs of supporting vertical integration. This should consider recommendations from the Prisoner Mental Health Care Taskforce and recommendations made because of the review of sentinel events and SAC 1 and 2 incidents. Furthermore, it should address the issue that currently there is a major difficulty for clinical staff in certain settings in knowing the status of certain people under the *Mental Health Act 2013* and potential for misadministration of the Act if this is not known. In the short term, all mental health sites, including those in inpatient units, should immediately migrate to the current statewide clinical information system, the DMR, so critical clinical information is immediately available to all relevant staff.

Horizontal Integration

The Taskforce found some good examples of horizontal integration. For example, there are partnerships that have been developed between public mental health services and key community-managed organisations that allow an individual to have people who have skills with providing disability support and clinical interventions to work together on a person's recovery plan. In addition, there are examples of partnerships between sectors that provide good coordination of a person's needs. This means that for those people who live with enduring mental illness who have significant levels of psychosocial disability, they have both a case manager who is involved with the clinical aspects of their care as well as workers from social sectors who can help the person with other

needs. The Taskforce found pockets of good coordination and collaboration, where services worked with both the person with mental illness and their family or carer but that this was becoming increasingly difficult to sustain.

However, the Taskforce heard that for most people in the sector, whether they were someone with lived experience of mental illness, the clinical sector or a disability or social service provider, this was the area of integration that needed improvement.

The Taskforce noted the following key issues in Southern Tasmania:

xxix. Mental health services have traditionally been established with a view to ensuring efficiency for the provider organisation and, taking into account the needs of the organisation rather than the consumer. Funders and service designers from both State and Commonwealth Governments have usually established service specifications and expectations for new services that lead to this situation and it has created further siloes. This is especially the case with "pop up" or temporarily funded services that are often designed to address a newly identified gap;

xxx. The way services are contracted, and the uncertainty of ongoing funding is also a barrier to integration. Consequently, services are often provided from a range of centres creating challenges for someone with multiple complex issues regarding access, as well as preventing the providers from easily communicating with one another about how they are assisting the person's recovery. The Taskforce found that the current system in Southern Tasmania is like the system described in the National Mental Health Commission's 2014 *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Service*s: "a collection of often uncoordinated services introduced on an ad hoc basis, with no clarity of roles and responsibilities or strategic approach that is reflected in practice"[42];

xxix. Services that require linkage between clinical and non-government operated services are often met with suspicion from clinical services. This lack of trust and confidence has led, at times, to a lack of referral and significant under-utilisation of new services;

xxx. Parts of the mental health service are unclear about their role within a person's recovery process, such that at times, clinicians undertake functions that may be better undertaken by either vocationally trained staff or peer workers. This can be because services may not be readily available, while at other times the availability of the service is not known, not accessible or not part of an integrated system. This can lead to over-worked clinicians performing roles that are best done by others;

xxxi. For example, the Safe Haven services in the United Kingdom provide an evening or weekend drop-in service for people experiencing mental health crisis, or suicidal distress, where primarily peers and wellbeing support staff with the back-up of onsite clinical staff provide this service;

xxxii. The Taskforce found few examples of people with mental illness, or their family or carers, who knew what services were available, how to access information about the service, and how to navigate the service system. In addition, a range of services that may be available to access a range of social supports maybe unknown to key staff. This is primarily because the current system has not developed processes that facilitate coordination of available components built around the needs of the individual. The Taskforce contrasted this with descriptions it heard of

[42] National Mental Health Commission, 2014, *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services Summary,* page 4.

the value of both LAC and Service Integration Coordinators that have been successfully embedded elsewhere in Australia;

xxxiii. The Taskforce noted that one significant obstacle remained in the way in which the two levels of government who primarily fund mental health services, namely the State and the Commonwealth, commission services. While the *Fifth Plan* outlines expectations of joint planning, and over time co-commissioning, the current reality is that this is far from being achieved and that traditional approaches of top down decision-making, by governments, that is often a response to local "hot issues", rather than a long term agreed plan, is still the dominant model. This has led to the dedication of new resources to areas that are not in keeping with what the service system, or the person who wants to access that system, think are priorities; and

xxxiv. Finally, the Taskforce identified that in Southern Tasmania, the range of services required for people who live with mental illness to lead meaningful lives and fully participate in their communities, is significant and outweighs the services that are delivered. Moving to a more integrated system needs to acknowledge this shortfall and the impact of not addressing this shortfall will have on the effectiveness of a newly designed system.

Recommendations

The Taskforce recommends the following on horizontal integration:

13. The DoH and the THS adopt a new service element as a central new feature of the community mental health system; namely, a 24-hour integrated service hub that consists of a range of collocated social services, disability support services, peer-operated services and clinical services, built around ensuring the recovery concept and supported by subacute residential services. The hub should primarily focus on supporting a person's recovery and meeting their care needs. The approach should be welcoming, free of stigmatising institutional approaches and have peer workers as a central role.

    The hub should be able to support the Safe Haven concept from the United Kingdom, as well as being an opportunity to provide a non-clinical option for those people who are in suicidal distress but do not need medical care, as an alternative to presenting to the Emergency Department at the RHH. This requires a consideration of how other clinical and non-clinical responses for people who are in suicidal distress or need aftercare are provided.

    This new service element should consider how to provide a LAC approach for those people with mental health issues who use this service as well as how an approach to Service Integration would be facilitated;

14. The Tasmanian Government considers the adoption of this service element within the current election commitments for the redeveloped Peacock Centre and the subacute services at St Johns Park. These would represent ideal sites to trial this new model of integrated place-based care;

15. The DoH together with the MHCT undertake a project to explore the best way of achieving greater integration of the full range of disability and social services that may need to be accessed by a person as part of their full participation in their community. This should explore not only Tasmanian Government funded programs but also those of the Australian

Government and Local Government. This project should identify the most effective way of utilising LAC and Service Integration in settings other than within the integrated centres;

16. The DoH develops an approach that would allow the ability to have flexible funding through the community-managed sector in Tasmania that would support the provision of services that promote greater horizontal integration, either at the integration hubs or in other parts of the community mental health system.

17. The DoH works with Flourish Mental Health Action In Our Hands Inc. (Flourish), Mental Health Carers Tasmania (MHCTas), the MHCT and the SMHS to develop a model to trial the transferability of the Recovery College concept as an element within the integration hubs.

Chapter 6 Implementation

The Taskforce devoted a lot of attention to the issues it considered directly related to implementing the reform of better integrating mental health services.

What was Found about Implementation?

xxxv. The Tasmanian mental health system has a varied workforce. By far the great majority are dedicated and hard-working. A range of local staff have also sought additional placements and training. Staff have also come to Tasmania from elsewhere and have brought their experience of working in more contemporary and better integrated services with them. Such staff have brought much needed expertise to the state. Many staff have however, worked their whole careers in Tasmania, and a large proportion of these are coming toward the end of their careers. As such, many of these staff have not had the opportunity to experience the most modern and innovative systems of care that are available in international settings. The Taskforce found that, overall, the workforce was not well prepared for a move to a more fully integrated approached as envisaged by *Rethink* or in line with the deliberations of the Taskforce;

xxxvi. The Taskforce observed a lack of curiosity about reforms and best practice occurring elsewhere in the world. The tension between traditional ways of providing services, which has been the mainstay of good clinical services in Tasmania, and a new paradigm in which the overall needs of a person can be met in different ways cannot be under-estimated.

The Taskforce noted the requirement for momentum to embrace change and a critical mass of people who are early adopters of new models to achieve a change to the way that services operate. Early adopters need to be in positions that can influence and support change at all levels within the system, and support from a dedicated implementation resource. This is in the context of a system exhausted by a series of changes of many years which has often been either poorly understood or has not been accepted by those who have needed to change their approach.

Finally, the tenuous state of the Tasmanian mental health workforce should not be understated. Like other parts of Australia, recruiting a sufficient workforce has become increasingly difficult. Tasmania relies on processes that are principally in the hands of the Commonwealth and the tertiary education sector to assist with the provision of a local home-grown workforce, or one that already has these skills but is not currently residing in Australia. While the THS helps with training, supervision and placements to assist the future workforce this also represents inherent costs to service provision. Furthermore, addressing this issue will have to occur within a competitive market; Tasmania will be up against other national and international markets all of which are facing similar challenges. Processes to alleviate this situation must become more timely, flexible and stream-lined to allow the provision of a future workforce capable of providing services in an integrated manner. This may well be equally applicable to health professional as well as disability and social service providers;

xxxvii. The Taskforce found that apart from some recent examples of services taking the initiative to open and welcome all stakeholders within their community, there has been a lack of a culture that meets regularly to better understand how services can work more closely. Indeed, it was pointed out that workshops of the size and nature of the Taskforce have not been conducted in Tasmania for almost ten years, during which time the landscape in Tasmania has drastically changed. This has meant that people have often never met or do not get together to understand each other's role. It was clear that in many cases, even Taskforce members did not know or understand the role and function of many parts of the sector, including peak bodies. The Taskforce heard that barriers have previously been in place that have made partnerships difficult to form;

xxxviii. The Taskforce heard previous instances over many years where innovation and personal initiative has been hindered. Of note was the belief, rightly or wrongly, that resourcing of services, policy and planning have been cited as the reasons why services should not change;

xxxix. The Taskforce found that the sector broadly accepts that the system should be built around achieving recovery, embracing trauma-informed care and practice, and the equal involvement of carers as outlined by the "triangle of care" concept. However, it found much of what is practiced currently is not in keeping with these underlying paradigms and the workforce has not been suitably prepared to fully embrace them;

xl. The Taskforce found the THS has little in the way of resources to manage such a significant change process. It has few if any available trained project staff and few with the time and skills to develop the range of tools needed to introduce a new system. In particular, the current SMHS does not have well-articulated and consistent models of care built around the concept of being fully integrated either from a vertical or horizontal perspective. Without a roadmap it is hard to see where to go;

xli. Most fundamental is the concern about what is to be integrated. The Taskforce makes the strong point that, when services fall below a critical mass of capability to provide their core tasks, they are not able to then either add in new tasks or even reform their current models of care to enable integration. This aspect is currently considered to be of most importance to the THS's community mental health services that have seen rising demand now far outstripping their capacity to provide services. As Leutz put it in his second 'Law'; "Integration costs before it pays". This will need to be taken into consideration as part of implementation.

xlii. The Taskforce raised the issue of leadership and accountability. There is currently no existing process that outlines who is responsible for implementing the major outcomes of integration reform as outlined in *Rethink*, the timeframe for such a reform and how progress would be reported. In the absence of this governance, a challenging, if not overwhelming undertaking has been left un-addressed.

xliii. The Taskforce also noted Leutz' fourth 'Law'; that is "you can't integrate a square peg into a round hole". This notion explains why horizontal integration has been so difficult. Primarily clinical care and social care are inherently different in the way in which they are funded, organised, administered, accessed and oriented. That two levels of government and often multiple different government departments where competing outcome frameworks, output reporting, and quality and standards frameworks might apply, makes the system too difficult for small providers to move between the peg and the hole. While much work has been done in North America, the United Kingdom and parts of Europe to consider the best approach to

overcoming this issue, the Taskforce is only aware of some efforts in Australia many of which have not successfully overcome this issue;

xliv. The Taskforce also found a central concern relates to Leutz' third 'Law', that is "your integration is my fragmentation". For many mental health clinical staff trying to get better integration outcomes may mean that they need to fundamentally change the way in which they liaise with a range of other providers. A process that attempts to avoid what has been described as "consultation and change fatigue" will be critical to the success of the integration approach;

xlv. The Taskforce also found that a key consideration must be how to identify the right person to take charge of integration. This is not only about implementation, but about which model of integration is applied. Key to this is that implementation needs to be led at the local level by those who share a common vision and with the authority to enable change to occur;

xlvi. There is also strong support for the model of an individual's integration being a flexible approach that differs according to the person's strengths and vulnerabilities. This will necessitate dealing with challenges that arise utilising supported decision-making and in recognition of the fundamental principles outlined in the United Nations *Convention on the Rights of Persons with Disabilities;*

xlvii. The Taskforce makes a distinction between what is needed to achieve best practice integration and what can be achieved quickly. Integration will be a lengthy, complex and difficult journey with many obstacles along the path that will be difficult, but not impossible, to straddle. Therefore, it is important in the beginning to achieve an agreed commitment to form better linkages and to commence coordination as without these initial steps, integration is unlikely to be possible;

xlviii. Finally, it is important that integration is tailored to what is appropriate. This means that for some who have multiple issues and have enduring problems, a full range of services may need to be integrated, while for others, there will be less need for integration and the range of services they will need is far more discreet.

Recommendations

It is recommended by the Taskforce that the following approach is taken to implementation:

18. That the Tasmanian Government set a timeframe for the adoption of a fully integrated approach within the Tasmanian mental health service. It is recommended that this date be 1 January 2021;

19. That the DoH note the significant undertaking to move to an integrated service system and agree to the development of an endorsed program structure to oversee the process of implementation (henceforth referred to as the Reform Program). The Reform Program should identify, at the very least, an overall Executive Sponsor who is accountable for the program, the resources available to undertake this reform process and the program deliverables, proposed outcomes, communication and change management processes. The Reform Program will need dedicated resources and an extensive commitment by all levels of the SMHS to ensure a range of complex and inter-related projects that would comprise this reform are successfully undertaken. It is predicted that the reform process will take at least 18 months if satisfactorily supported.

The Reform Program should also have a clear schedule of reporting on progress on at least a three-monthly basis.

The DoH and the THS need to agree on an approach to managing the critical success factors associated with implementation. It is unlikely that the Reform Program could commence within two months of the acceptance of these recommendations. As it is anticipated the timeframe for implementation is 18 months, any delay to commencement impacts on a proposed commencement date for integration.

The Reform Program will need to prepare a shorter document than this report that outlines the case for change, that is then used as the basis to ensure the entire sector is preparing for the reform. It will be fundamental that regular communication of the process and its progress is shared with all staff and the sector more broadly.

The Reform Program should be built around the principle of evidence and best practice in relation to co-design and both Flourish and MHCT should be key partners in all aspects of the program. Furthermore, the MHCT, and primary care need to be involved in the design of the Reform Program;

20. The THS will need to identify a range of workforce reforms that support this process. This will include how all clinical staff can demonstrate that they are competent in the 16 values and attitudes contained within Standard 9 (Integration and Partnership) of the updated *National Practice Standards for the Mental Health Workforce 2013*[43]. This Standard, together with Standard 9 (Integration) of the *National Standards for Mental Health Services 2010*[44] are key documents that should set out the expectations for an integrated system of mental health care.

    Furthermore, the THS should consider the degree to which the National Framework for Recovery-Oriented Mental Health Services[45], the "triangle of care" concept and the principles of Trauma-Informed Care and Practice are known and adopted by all clinical staff. These three frameworks are considered fundamental to successful integration. The SMHS will need to determine what investment is needed to ensure staff have competency with these approaches.

    The THS will need to address significant obstacles arising from its current culture to ensure successful implementation; and

21. It is recommended that the recommendations within this report are used as the basis for exploring whether they are equally applicable in the North and North-west regions of Tasmania. It is the Taskforce's recommendation that they apply.

[43] State of Victoria, Department of Health, 2013, *National Practice Standards for the Mental Health Workforce 2013*.
[44] Commonwealth of Australia, 2010, *National Standards for Mental Health Services 2010*.
[45] The Framework was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) on 12 July 2013 and formally launched by the Chair of AHMAC at the Mental Health Services Conference (TheMHS) on 21 August 2013. The Framework is presented in two companion documents, both of which can be found here: www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

Chapter 7 Appendices

Appendix 1: Taskforce Membership

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Sean Beggs
Richard Benjamin
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Ben Elijah
Matt Fasnacht
Chris Fox
Mark Frohmader
David Gardiner
Adie Gibbons
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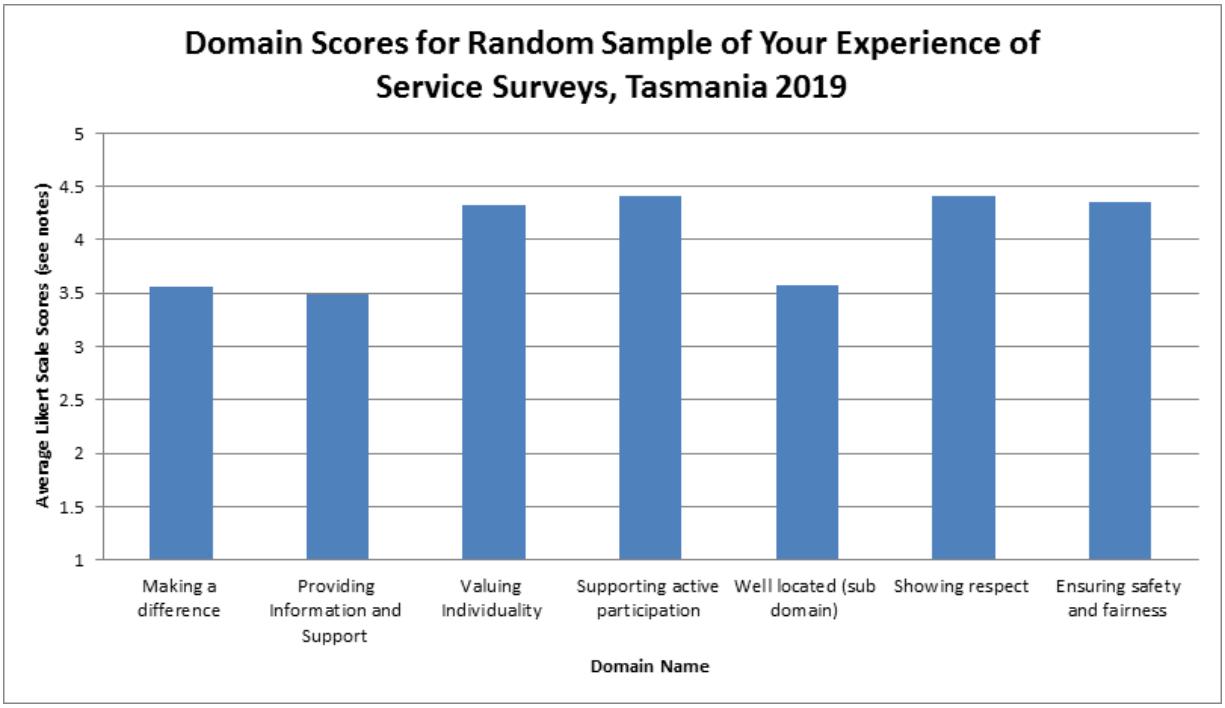
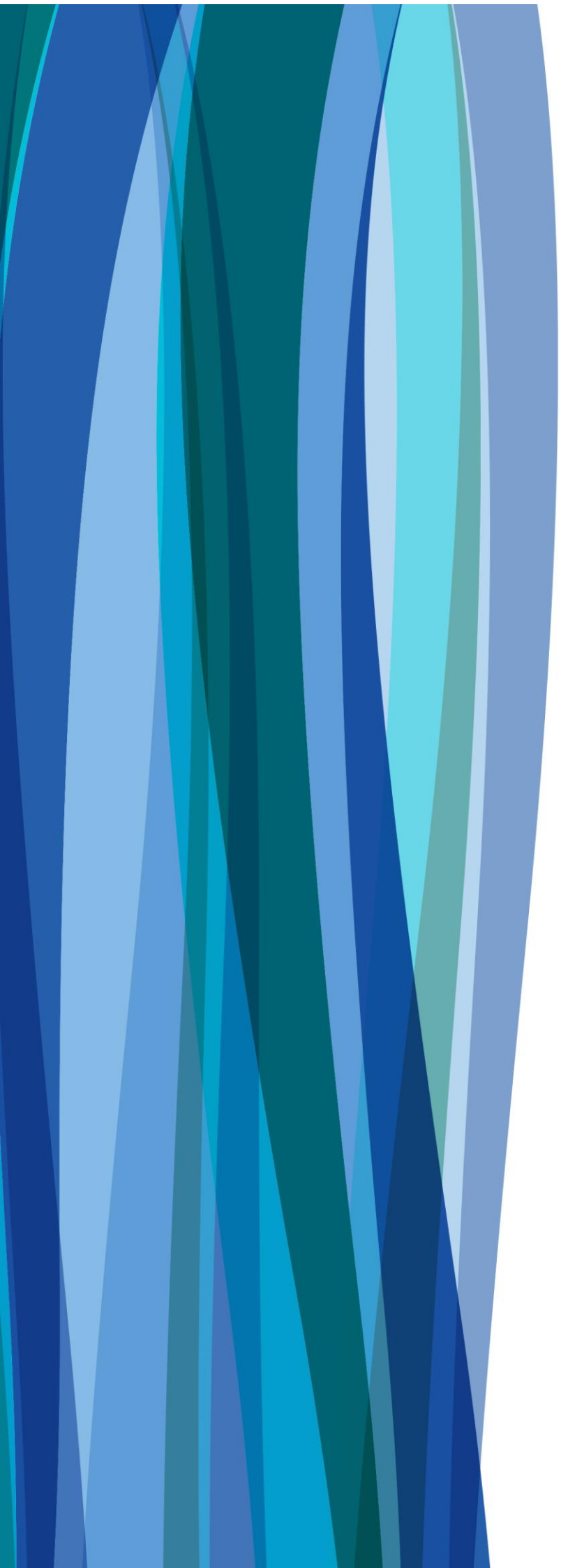
Aaron Groves
Emma Huckerby
Russell James
Mike Jordan
Fiona Judd
Leila Kavanagh
David Lang
Tom Lynch
Milford McArthur
Sue McBeath
David McDougall
Louise Megson
Robbie Moore
Barry Nicholson
Honor Pennington
Vicki Polanowski
Jo Poole
Meg Power
Adrian Reynolds
Dean Riches
Cat Schofield
Emily Shepherd
Clare Smith
Kate Shipway
Deb Solomon
Jo Triffitt
Fiona Wagg
Lennie Woo
David McDougall
Liz Webber
Julie Martin

Appendix 2: Your Experience of Service



NOTES:

Domain Name	Description
Making a difference	This domain describes how the service contributed to outcomes for individuals. It includes emotional and physical health.
Providing Information and Support	This domain describes how the service works for the individual. It includes resources such as written information, a care plan, and access to peer support.
Valuing Individuality	This domain describes how the service meets the individual's needs. It includes sensitivity to culture, gender and faith and the importance of personal values and beliefs.
Supporting active participation	This domain describes how the service provides opportunities for individual choice and involvement in the process of service delivery.
Well located (sub domain)	This domain includes a single question about the convenience of the location of the service for the individual and their family. It includes access to public transport and other facilities.
Showing respect	The domain describes how the service provides the individual with a welcoming environment where they are recognised, valued and treated with dignity.
Ensuring safety and fairness	This domain describes how services provide individuals with a physically and emotionally safety environment.



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