Government of South Australia

Health
Flinders and Upper North Local Health Network

Flinders and Upper North LHN Inc.
Mental Health Services

SALTBUSH Rehabilitation Service

Service Plan

Updated August 2022


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Contents

Service plan

The Operating Guidelines are to be read in conjunction with the Saltbush Service Model and the Saltbush and CMH procedures

Roles and Responsibilities

As part of the integrated program, Saltbush will be multidisciplinary in its delivery whilst all Community Mental Care Coordinators retain a role. This includes participating in reviews to ensure continuity of care co-working with colleagues and other disciplines. The inclusion of Nursing, Occupational Therapy, Social Work and Psychology supported by psychosocial support workers brings discipline specific skills and knowledge offering a range of interventions to suit consumer need, in a flexible model of integrated care. Clinicians may provide regular care or support across Saltbush or work with the consumer towards an identified goal or across a discipline specific therapeutic intervention.
The Multidisciplinary Saltbush service will have key roles and responsibilities embedded to ensure day to day clinical practice and support worker care is coordinated and collaborative but also has the flexibility to utilise discipline specific interventions as required.

Saltbush Team Leader

- Has overall leadership responsibilities for the Saltbush team
- Chairs the allocations (referral) committee
- Responsible for rostering and oversight of Saltbush

IMHT Consultant Psychiatrist

Has responsibility for clinical services provided by the IMHT across levels of care

- Participates in clinical meetings and decisions to step up/step down
- Awareness of the consumers participating in Saltbush

Rehabilitation Co-ordinators

Specialist mental health care provides clinical assessment, therapeutic interventions aimed at symptom management and minimising or reducing impairment associated with mental illness. This will include use of medication, psychological therapies and clinical rehabilitation interventions and a focus on the development of self-management skills. Clinical Mental Health Services will provide a clinician (Rehabilitation Coordinator) who provides on-site leadership and supervision to other staff members and ensures that Saltbush remains linked into the stepped system of care.

The Saltbush clinicians will be responsible for:

- Providing planned clinical mental health support.
- Rehabilitation Coordination services - one clinician will be allocated to primarily coordinate a consumer's care however, all workers will be expected to have input into all consumers plans and respond to the immediate needs of consumers.
- Documenting the Mental Health Care Plan and Rehabilitation Plan in collaboration with stakeholders, especially the consumer and carers.
- Providing a range of clinical assessment, clinical rehabilitation and care coordination. They will also be responsible for reviewing services and coordinating access to other health services as required.
- Facilitating access to other mental health services as required, e.g. living skills assessments, psychological therapies, psychiatry services, etc.
- Addressing medication and physical health related issues. A graded program to support consumer's self-management of medication occurs for every consumer of Saltbush – and this is led by nursing staff. Clinical staff are responsible for completing referrals that support consumers to link to appropriate services to meet their needs including GP's, dental, podiatry, dietician, psychiatrists, psychology services, return to work programs, etc. Additional details will be outlined in the operational guidelines.
- Undertaking clinical assessments for referral and regular review using RAS-DS, HoNOS, K10+, risk assessments, mental state examinations, LSP and Care Plan. Undertaking discipline specific assessments when required.
- Carrying out and reporting against legislative requirements, including: Mental Health Act, Guardianship and Administration Act, and Criminal Law Consolidation Act.
- Overseeing clinical care, treatment and rehabilitation, including planning processes relating to the transition to, participation in the CCRC program and transition from Saltbush.
- Reporting on KPIs.

Rehabilitation support staff

- Providing individually planned psychosocial recovery and support services on a daily basis, as required by the consumer, with a focus on building independent living skills and community engagement (such as support personal care, shopping, home care, cleaning, etc. This will include support at all phases of the rehabilitation continuum.
- Working with consumers support the implementation of a recovery oriented Rehabilitation Plan which is reflected in the Mental Health Care Plan.

Hours of operation

7 days a week and provides a service from 08:00 – 20:30 and this operates across two shifts.

8:00 – 16:00

12:30 – 20:30

With optional targeted on call depending on clinical need.

Consumer profile

The service is aimed at supporting people with a primary diagnosis of mental illness who have high and complex needs and with some or all of the following features:

- Significant functional disabilities are indicated in the areas of life or social skills and self-care resulting in significant rehabilitation needs.
- Would benefit from intensive rehabilitation management due to significant impact of their mental illness.
- Would benefit from living in a supported residential environment to assist in returning to achievable and sustainable level of independent living.
- A person's need cannot be met by a less restrictive option, or trials of periods of less intensive community support have not been able to meet the consumer's needs.
- The person does not pose a significant risk to themselves or others.
- Be willing to live in a shared living environment (if required, due to single accommodation not being available).
- Be willing to participate in a planned rehabilitation support program.

Individuals are likely to have one or a combination of the following characteristics:

- Unremitting symptoms resulting from mental illness.
- Have not succeeded at independent community living previously.
- Risk factors including complex health (medical and allied health), lifestyle and/or behavioural needs and co morbidities.
- Patterns of difficulty in engaging with services creating risk to self and/or others.
- Lack of natural support from family/friends and/or connectedness with the community.
- Significant grief and loss issues impacting on long term mental health.
- May have a complex trauma history including experience with interpersonal violence, adversity and exposure to trauma over extended periods of time.

Participation in the service is voluntary. It is acknowledged that some people will, at times, need supportive encouragement to engage with the CMHRS program until they feel safe and secure.

Homelessness, experience with the criminal justice system, orders under the *Guardianship and Administration Act (1993*), *Mental Health Act (2009)* and/or the *Criminal Law Consolidation Act: Mental Impairment Provisions* do not impact on eligibility.

Waiting Lists and Priorities

Timely and coordinated access to Saltbush will be upheld. When waiting lists evolve, the Team Leader will keep consumers informed and manage the development of a priority waiting list. In determining priority for access to Saltbush, the following should be taken into account:

- Priority should be given to those with the highest levels of disability – this is regardless of diagnosis or capacity for rehabilitation/change.
- When there is more than one eligible person with similar levels of disability and need, priority should be given on the basis of length of time someone has been waiting for a service.
- Where a vacancy in the service arises requiring a person to live in a shared accommodation setting with another resident, issues of gender, cultural and need may determine priority.

CCCME documentation

- Each contact will be documented in CCCME under the Saltbush code.
- Care Plan includes consumer goals
- GP identified and updated if required
- Family and significant other and or Carer/NGO contacts updated

Therapeutic framework

Saltbush is delivered within the *South Australian Framework for Recovery-Oriented Rehabilitation in Mental Health Care (2012)*. The framework is a recovery-oriented rehabilitation framework to provide individually targeted interventions to assist people to regain, build or develop skills which enable consumers to engage in their recovery process.

Mental health rehabilitation is the process of facilitating an individual's skill development, and may include re-acquiring old skills and learning new skills, so that an individual can achieve their optimal level of functioning, community participation and quality of life in their community of choice.

Rehabilitation specialists with clinical training and experience provide individually tailored rehabilitation assessments, interventions and services. They may also act as rehabilitation consultants to other mental health services.

Individualised, baseline and multidisciplinary assessments of functional ability are implemented using a recognised functional assessment measure. The assessment informs the development of an individualised rehabilitation plan with mutually negotiated rehabilitation goals and indicative time frames. The consumer works with the members of the multidisciplinary team to develop this plan which identifies and builds on their strengths.

The provision of a graded approach to rehabilitation away from disability support is emphasised. At times workers may need to assist with or do tasks for individuals to enable them to focus on other areas of skill development however the disability support provided may only be for components of tasks, or for specific tasks. This (disability) support must be targeted, regularly reviewed and coordinated as a part of the service Plan and may be delivered in collaboration with NDIS.

Individual Rehabilitation Plan (IRP)

All participants are expected to have a comprehensive assessment from which an Individual Rehabilitation Plan (IRP) is developed. The aim of the IRP is to facilitate an individual process of recovery and to assist participants to regain their place as an involved member of the community.

A thorough assessment with the person on entry to the service is important in identifying and developing strategies to address identified goals. While the person referred is the main focus of the assessment, families and carers will be important advisors as to the issues and best approaches, as well as other services with whom the person has been involved including case managers and community service providers.

People referred to Saltbush will generally have multiple and complex needs that require the

involvement of a range of service providers within and external to the service. The development of an (IRP) is an important process that identifies the needs of the person, their family/carer and services involved to ensure integrated and coordinated treatment, care and support is put in place that maximises the recovery outcomes. The process requires the active engagement of the person and their family/carer and other relevant service providers in the partnership of care.

The plan is centered on the consumer and identifies areas of focus, activities and responsibilities.

A comprehensive IRP should contain:

- A description of the participant's current situation.
- The participant's goals and the supports needed.
- Detailed strategies for achieving those goals. In relation to long-term goals, phases for achievement of those goals should be factored into the IRP.
- Indicators for assessing when and whether those goals have been achieved.

While the scope of the IRP is an individual decision, the Saltbush Rehabilitation Co-ordinator should ensure a range of areas are explored in the assessment including understanding of the illness, coping strategies, daily living skills, self-care, relationships, social skills, accommodation needs, and educational, vocational and recreational goals. It should be written in clear, unambiguous, accessible language.

The period of time needed to develop an IRP will vary, depending on the participant's level of trust. However, services should aim to have an IRP in place within six weeks of a person commencing with the service.

A less formal approach to developing an IRP may be necessary for those participants who may find it difficult to engage with the service, for example those who have experienced significant transience, homelessness and trauma or who state that they do not want to be involved in the development of an IRP.

Whether or not a formal written IPP is developed, the process of engagement and exploration of a participant's goals, aspirations and needs is an integral part of involvement in structured rehabilitation program as part of the service participation.

The IRP should be reviewed at regular intervals (at least six-weekly) by a Saltbush Rehabilitation Coordinator, the participant, and other appropriate people such as family and Community Mental Health Team Care Coordinator. Participants, Community Mental Health Team key worker or their Saltbush Rehabilitation Coordinator may initiate reviews of the IRP at other times. These reviews may take place face-to-face or using teleconferencing and videoconferencing facilities. The consumer's treating GP will also remain engaged and informed of their care or this care will be negotiated with a local GP.

Transition from the Service

Transition planning commences at point of entry and will usually be staged over a period of time as residents will be supported to transition back to their community of choice. Systems are put in place for ongoing care, support and follow up. Transition planning is clearly outlined in transition documentation and made available to all appropriate stakeholders. Links with the resident should be maintained, where appropriate, during the transition period.

The consumer can choose to leave at any time. However, they will be encouraged and supported to remain engaged in the program and to address the reasons prompting early exit. This assumes assessment and management of risk.

The consumer may be asked to leave if in constant or persistent breach of their Residential Agreement and/or their behavior is negatively impacting on other resident's rehabilitation.

Housing

Saltbush will provide accommodation for the term of a persons' participation in the service – individual or shared accommodation located in residential settings. The accommodation will cater for the needs of consumers across genders, age and cultural needs and in relation to privacy, personal space, safety and needs.

Housing is fully furnished and provides a safe, home like environment in which the individual contributes to daily household tasks and activity as part of their rehabilitation journey. Residents will have access to their own private space (bedroom) and bathroom as well as access to shared spaces (indoor and outdoor).

Consumers who reside in Saltbush properties are expected to pay a resident fee as per their Resident Agreement. The amount of rent payable depends on the consumer's income, and

is comparable to social housing rent – which if a person is on the Disability Support Pension is a maximum of 40% of income plus Commonwealth Rental Subsidy. If an individual currently pays rent elsewhere which is equal to or more than social housing rent and this must continue in order for them to maintain their place, the rental fee at the Saltbush property may be waived or a reduced rental fee based upon an individual's financial circumstances may be considered. Additionally, if rent would cause undue hardship rental payments would be review based upon that individual's circumstances.

Family and social connections will be encouraged, and support and visits will be promoted. Saltbush can provide and assist to identify appropriate local accommodation and support during family visits. Family members are not able to stay in Saltbush properties and will need to organise an alternative accommodation.

It is expected that consumers are willing to accept support and remain engaged with Saltbush support services for the duration of their tenancy. If the consumer is unable to engage with the service over a continued length of time, then termination of their residency and participation in the service may be considered.

The fostering of positive relationships between residents, neighbours and local community members is important and will be actively fostered. This includes establishing effective communication strategies to minimise the potential for conflict and reduce the stigmatisation of the service participants and people with a mental illness.