



2022
72 BED MODEL OF CARE
WORKSHOP 2
Briefing Report
SA HEALTH

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Report

Purpose:

Workshop 2 – To continue the discussion regarding the newly announced Government funding grant for 72 new Mental Health specific beds across South Australia. The second workshop is to explore who shorter term inpatient rehabilitation will be helpful for; and to work through how their journey might look. The workshop is to also consider what staff mix and values will be needed to deliver the service. Discuss how we will know that the units are successful (consumer outcomes, carer experience, system/service impact).

Recap Workshop 1:

- What does the Model need to reflect?
- Rehabilitation must be a pathway into something else, whether that is community living, supported living etc – this can not be a long term home or inpatient service.
- Must be voluntary, person focussed and tailored to the individual
- Important to have a home like feel and to provide opportunities for development of life skills
- Peer led and care informed by lived experience
- Community connection is prioritised
- Remove the attitude of ‘rehab ready’
- Clear outline and guidelines on what the Facilities are not to be used for.

Overview of process:

1. 3 hour workshop facilitated with approximately 40 attendees
 - a. Group Discussions
 - b. Questions and Answers with Director Policy, Planning and Safety – Liz Prowse and Mental Health Commissioner – John Mannion
 - c. Workshopping and collation of ideas and feedback for dissemination and future use.

Workshop Discussion Summary Overview:

Aim :

No change to Workshop 1. Still to Develop an overarching Model of Care that will inform and direct Local Health Networks (LHNs) on how to provide their rehabilitation care services. Specific operational outcomes will be developed and managed by the LHNs. We are developing the high-level overarching guidelines/framework that will guide those operational outcomes. Developing an overarching Model of Care to inform the creation of new rehabilitation services.

Parameters and Constraints :

72 beds in 3 locations that need to be utilised for mental health rehabilitation. These workshops are an opportunity to step outside the constraints of 'usual rehabilitation' and build something that is fit for purpose instead.

Government commitment to build and open 72 new mental health rehabilitation beds:

24 beds QEH - \$53.7 million

24 beds Modbury Hospital - \$53.7 million

24 beds at Noarlunga Hospital - \$50.4 million

All 3 newly constructed wards will be operational within 3 years.

Breakdown of observations and data collated – Brainstorm Activities

Activity 1 – Who is the target consumer?

Who do you believe the beds should be for?	Why should these people be prioritised?	What would these people require during their short term rehabilitation?
Voluntary People who want to be involved in rehabilitation People who believe they will benefit from rehabilitation All levels of care (not only complex or acute) Suicidal without complex mental illness Young people feeling suicidal Early intervention and support Lower level support required (anxiety) Comorbid substance issues All stages of recovery journey Complex Persons with complex Mental Health needs Persons experiencing complex psychosis Persons with intellectual disability Persons requiring more than a short stay in hospital Needs weren't met in acute care Presentations/referrals Multifaceted referral – GP, ED, UMHCC, Self-referral, community mental health team Enable planned admissions Mental Health presentations at ED Transition Persons leaving acute care Transitioning into community Transitioning from youth to adult system Non acute Medically stable - Psychosis needs	General Support to stay in/return to community Optimise function and build independence Require space to stabilise Exhausted community options Reduce burden on current services Voluntary Consumer choice to engage Better chance of recovery Willingness to engage Motivated Complex Optimise function in a non-medical ward Reduce level of intervention Demographic specific Gender safe care Homelessness current barrier Transition Support for transition between systems Gap in service Non acute Free up system/space for those that are acute Early intervention Reduce recurrent hospital presentations	Environment Welcoming Non clinical No restriction Variation in beds Not high security No seclusion Home like feel Community input Therapeutic Sensory rooms Tailored approach Gendered pods Different pods/wards for different levels Slow stream & Fast stream Early intervention rehab Short-term and long-term beds available Variety of service available dependant on individual need Autonomy and self-directed recovery Safe space to explore risk helping to find safe limits – drug and alcohol use permitted Flexible timeframe Services Holistic approach Integration of First Nations knowledge of wellbeing Physical health programs Skills building Function improvement OT groups

Persons with BPD - not in acute crisis Community resources exhausted but acute bed not required Sub-acute presentations into slower stream 'Low risk' persons Struggling in community but hospital stay not required Lowered functionality across multiple facets of life Feel unsafe/at risk in community Demographic specific Female/AFAB only pods People 60 years and over not eligible for OPMHS Homelessness not a barrier		Emotional regulation skills Medication support Psychosocial support Consumer shared knowledge and experience Community service navigation and support Inreach from acute care Providers Peer lead at every stage Carer and family integration: education, input, connection Well trained recovery focussed staff Integrated support Access to outside providers (current and new) Encourage therapeutic community Lived experience staff Links to NDIS and NGOs Access to Allied health Support and engagement available 24/7 Pathway plan Plan for transition Linked to community services Visible celebrations at transition points
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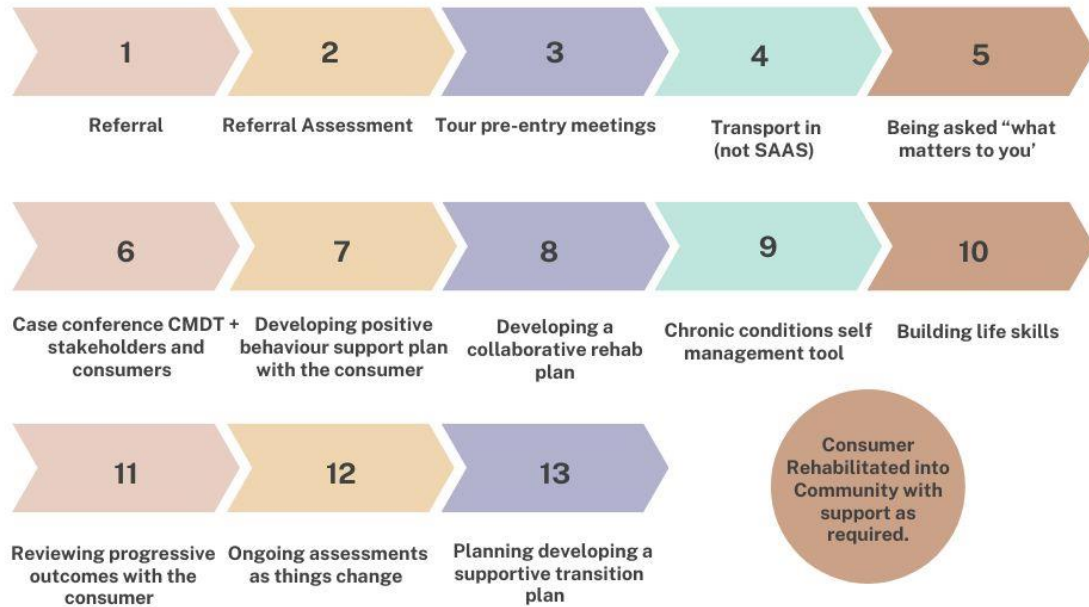
Activity 2 – The rehabilitation journey

Who are the key stakeholders on the journey?	Identify the steps along the journey	Identify potential hurdles for consumer in their journey
Consumer community Consumer Family Friends The public Employers Educational facilities Religious groups Carers Care team Rehab workers Clinical team GPs Peer workers Community mental health team Lived experience workers Doctors and nurses Government orgs	Considerations not mapped Step up and step down support (into and out of different care and systems) Goal identification at the start Multiple referral points In-reach from other programs and services Discharge planning from the beginning of process – set predicted expectations for duration of stay Transition plans Family meetings Early access to rehab Once medically stable demote acute to rehab Journeys mapped	System Application/process to complicated Highly medical jargon Inflexible system Wait listing Restrictive practise Clinical environment Bed pressures Difficult referral process Carers excluded from communication Exclusion criteria Lack of community connection Public trustee/guardians Homelessness – currently a barrier NDIS Sustainability of best practise model Lack of Rehab competencies Exit pathways

Minister Housing SA NDIS NDIA SA Health Public trustee SAPOL Hospitals (Emergency departments) Non GOS DASSA Community organisations Drug and alcohol services Allied Health OT Psychology Dietitian Speech path Psychosocial Providers of: Art Music Cooking Exercise Spiritual Cultural	Model 1 (Flow chart below table) Referral Referral Assessment Tour pre-entry meetings Transport in (not SAAS) Being ask “what matters to you’ Case conference CMDT + stakeholders and consumers Developing positive behaviour support plan with the consumer Developing a collaborative rehab plan Chronic conditions self management tool Building life skills Reviewing progressive outcomes with the consumer Ongoing assessments as things change Planning developing a supportive transition plan Model 2 Entry point – multiple referral sources Client self referral Clients/consumers come for a tour and have a chat with staff Assessment Rehab starts immediately Plan formulation – what will the journey look like What supports are needed before discharge Exit point	Workforce Staff turnover impacts relationships Staff shortages Pre-existing workplace cultures Values of service/staff vs Values of consumer Inadequate peer connections Lack of respect for identity (pro nouns, culture needs etc) Promotion of services Latrogenic harm Consumer Fear Stigma Past-experience or preconceived ideas of care Judgment/ feeling judged Feeling lack of progression Fluctuation of mental state Change in motivation Lack of autonomy Substance use Lack of cultural integration/respect Denial Lack of engagement Unhelpful families/ community networks Risk of getting stuck/ no transition Social isolation
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MODEL 1

Consumer Rehabilitation Journey



MODEL 2

Consumer Rehabilitation Journey



Activity 3 – Measuring success

Consumer Outcomes - What does success look like?	Carer Experience - What does this cohort need to stay well, supported and productive?	Systems and Service Impact - How can this new Model assist the Healthcare system and those within it?
Connection Connection to community Connection to self Peer connection and friendship Connection and participation in ongoing groups and support systems Emotional and psychological safety Feeling safe Re-engaging in interests and skills Improved quality of life Hopeful and optimistic Empowerment Choice in care/ autonomous decisions Meeting goals Improved confidence Future steps in place Consumer identified success Live safely and manage condition with outside resources/programs	Community Community connection and support Space for families and friends to visit Facilities hold space for carers to visit and input into care Support/empowerment Links to resources Respite options Links to support systems and networks Identify clear support plan Acknowledgment of role as carer Co-designed care	Reduction of active service presentations Help support the flow of the system from acute, ED etc. Aligned to ABF requirements To meet National benchmarks Build pride in service Carer support - coaching - financial services/grants - counselling

Insights:

Data gathered showed an engaged group of people all wanting to create something new and exciting for the State using the funding provided.

There was excellent teamwork during the brainstorming exercises and people shared openly and in a positive and optimistic manner.

The feedback on how participants felt at the end of the workshop is shown below as captured on the day.

Many participants commented on the day how positive they felt after the workshop and that the workshop helped them to gain clarity and insight into the process going forward.



Next steps:

- Utilise the data collected to develop the Model of Care. This will then help to inform and co-design the new rehabilitation services and facilities.
- Utilise data collected to commence workforce strategy and design for facilities.

Appendix A : Job and skill mix for workforce planning – Brainstorm Results

Holistic therapies	Medical staff	Lived experience	Support	Attitude/skills	Delivery
Art Music Dance Cooking Spiritual Exercise physiologist Gardener Chef General life profession to model skills and work alongside consumers	Phycologist Psychiatrist Neuropsychologist Doctors Nurses Dietician Occupational Therapist Allied health Pharmacy	Peer support workers Aboriginal staff LGBTIQ+ staff Peer workers in each area (through transitions and in ED)	NDIs liaison Carers Volunteers Counsellors Carer consultant Career counsellors Social workers Life skills coaching Relationship counselling Housing	Values based recruitment Recovery focus Clear leadership Team based approach to care	7 day access to all services (7 day roster allied health) Co run by NGO and clinical 1:3nursing ratio Diversity (culture, age, gender)

Appendix B : Participant names were provided to SA Health at commencement of workshop.