IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT MOB-16 TO STATEMENT OF DR MARK OAKLEY BROWNE

Date of document: 17 July 2015
Filed on behalf of: State of Victoria
Prepared by:
Victorian Government Solicitor's Office
Level 33
80 Collins Street
Melbourne VIC 3000

[redacted]

This is the attachment marked '**MOB-16**' produced and shown to **DR MARK OAKLEY BROWNE** at the time of signing his Statement on 17 July 2015.

Before me: [redacted]

[redacted]

MENTAL HEALTH

GUIDELINE

Discharge Planning for Adult Community Mental Health Services

Introduction

Management of caseloads in community mental health services is an important component of the provision of high quality mental health treatment and care to those who require specialist public mental health services. The intensity and type of service provided should be based on the clinical needs of the consumer and the range of services available within a broader, integrated health care system. Determination of the service provided to an individual requires regular review and consideration of alternative options. Active discharge planning and timely discharge decisions are central to this process.

The Chief Psychiatrist has a statutory responsibility for the medical care and welfare of those receiving treatment for a mental illness. The issuing of clinical practice guidelines is consistent with this responsibility.

Purpose

To provide approved mental health services with guidelines concerning practice in relation to case management and discharge planning in community settings. These guidelines are intended to:

- Provide a framework for consideration of issues associated with discharge planning
- Be adaptable to different service systems and resource availability.
- Promote an overall philosophy of active case planning, review and case load monitoring to improve the efficient use of available personnel and resources.
- Ensure that service provision is matched as closely as possible to individual clinical need within the resources of the Area Mental Health Service (AMHS).
- Promote collaborative discharge planning with consumers, carers and relevant service providers.

It is suggested that approved mental health services develop their own procedures and practices in relation to discharge planning that address the issues raised in these guidelines.

Victoria The Place To Be

Victoria Department of Human Services

Rationale

There has been a growing demand on mental health services in recent years including increased presentations to emergency departments of people with mental health issues. Decreased length of stay in inpatient units requiring active community management of persons who remain significantly unwell, and increased co-morbidity and complexity of presentation has added to this demand. To continue to provide appropriate services to those who suffer ongoing significant symptoms of mental illness and associated disability, services need to actively consider practices to ensure that whenever a person can be discharged to an alternative service provider, this is facilitated.

Unless discharge options are actively pursued where appropriate, there is a risk that caseloads will be excessive and that those who require specialist assistance will be unable to access that assistance. The services provided should always be congruent with the clinical need of the consumer, such that consideration of other services is appropriate when a person no longer requires intensive or specialist care. It is recognised that most people prefer and often find it more convenient to see their General Practitioner or private psychiatrist, rather than attend a specialist public mental health service. In addition, mental illness is often episodic and people who suffer mental illness should be able to flexibly enter and exit specialist mental health services as occurs in other specialised areas of health care.

Key Principles

- Consideration of discharge and preparedness to engage in discharge planning should commence at the time of entry into the service.
- Consumers and their carers as appropriate, should be made aware at the point of entry that services will be provided for the period clinically indicated.
- Active case management and case load monitoring requires the input of all levels of staff – this includes members of the treating team, Community Mental Health Service (CMHS) managers and consultant psychiatrists.
- Relevant discussions and clear communication between clinician, consumer, family/carer and the service/person who is to provide ongoing treatment is vital.
- Mental illness may be recurrent or result in chronic symptomatology. This should not preclude consideration of discharge to non-specialist or non-government health services.

Implications for Mental Health Service Staff

Those who provide a clinical service should be prepared to work with their clients on discharge planning. Regular clinical review and caseload audits should consider the required level of service, who should provide that service and whether alternative service providers are available.

While it is recognised that variations exist in the level and range of alternative services in different areas, as a general guide when a person reaches a stage of contact with the service less frequently than monthly, the possibility of discharge should be strongly considered.

While case management remains the cornerstone of community mental health service provision, the level and intensity of case management needs to be carefully matched to the individual's current need. It has been noted that some consumers remain in contact with a mental health service who on careful examination no longer require active case management. Some consumers may have infrequent contact, but nonetheless rely heavily on such contact. In such cases, services may consider how this need might be met by a shared care arrangement, with care being primarily provided by the general practitioner or private psychiatrist and Psychiatric Disability Support Services.

Policy Context

Victorian public mental health services provide specialist treatment and care in the least restrictive environment consistent with the effective giving of that treatment and care. Treatment is provided in the community wherever possible. Public mental health services are provided within a broader integrated health care system that includes General Practitioners, Community Health Centres, private psychiatrists and other practitioners who also provide clinical mental health care. Psychiatric Disability Support Services provide home-based, residential support and community day programs. Specialist public mental health services are expected to work collaboratively with these services to foster and retain close links to ensure a seamless service to consumers.

Community based mental health services include Crisis Assessment and Treatment, Mobile Support and Treatment, Continuing Care, Community Care Units and Homeless Outreach Persons services. It is expected that these components will work closely with each other to ensure the most efficient use of available resources consistent with the care and treatment required.

Relevant policy in relation to community mental health services is provided in *Victoria's Mental Health Service: The Framework for Service Delivery, 1994, and* the role of case management is detailed in *Victoria's Mental Health Services: Improved Access Through Co-ordinated Client Care, 1996*. While stressing the importance of case management in engagement and continuity of care, and in providing a contact point and responsibility for consumers and carers, these documents clearly envisage considerable variation in the level of provision of case management required at different points in the course of treatment and care.

Definition of Mobile Support and Treatment Service (MSTS)

The MST Service provides intensive community treatment to consumers with severe mental illness and associated disability. In many cases this service will avoid or minimise the need for repeated and lengthy hospital admissions. It is envisaged that MSTS consumers will need from time to time to move flexibly between Continuing Care and Crisis Assessment Team functions where this is clinically indicated. The specific focus of the MSTS is for those who:

- Are especially prone to relapse of their illness and have a wide range of psychosocial rehabilitation needs that would typically result in the consumer's frequent and or lengthy admission to hospital;
- Who commonly experience difficulties with treatment regimes or have treatment resistant illnesses or require early intensive support for both consumer and family in a first episode psychosis;
- Typically require intensive input from other community based services, and
- Suffer problems with motivation and ability to function independently and have a poor understanding of their mental illness despite ongoing education.

Definition of Continuing Care, Clinical and Consultancy Services

Continuing Care, Clinical and Consultancy Services provide a range of community based services for assessment, treatment and consultation in addition to continuing care and case management. These services provide:

- An initial assessment for people requesting assistance where a CAT service response is not indicated.
- Ongoing case management focusing on the seriously mentally ill who require treatment, monitoring and continuing support.

Services will be closely linked with the bed based and other community based services. Strong links will be required with local non-government agencies to assist consumers with multiple needs and may require housing support, day program support as well as assistance in the development of a range of community living skills.

Discharge Preparation and Planning

Entry into Service

Whether a person is in the inpatient psychiatric unit, self-referred or from another service provider, there should be a formal plan formulated in consultation with the consumer and carer as appropriate. The plan should be based on a comprehensive assessment of need that also considers the likely duration of involvement, the issues to be addressed including active strategies for discharge. Information and consultation regarding the service to be provided should be conveyed to the consumer, carer and referral source as appropriate to ensure mutual expectation and understanding. The information and attitude conveyed by the triage or duty worker is of the utmost importance in developing shared, realistic goals.

Engagement with the Service

All persons engaged in ongoing treatment with community based mental health services should have a designated case manager. However, the level of case management should be matched to clinical need and may range on a continuum from nominal case management to more active and assertive case management. Nominal case management is usually provided for those who no longer require active or more frequent monitoring from the case manager and are awaiting discharge or referral to a primary health care provider. Other persons who may be considered for nominal case management are those with serious mental illness who are prone to relapse and with associated risk factors who despite best efforts are typically reluctant to engage, may have no psychosocial issues they wish to address and where some ongoing monitoring from the service is indicated.

Those in an acute phase of illness or those receiving Mobile Support and Treatment level of input will require the most intensive and frequent contact. The role expectations and responsibilities of case managers at the various levels of case management should be clearly detailed in local policy and procedures. Each client's care plan should also denote strategies and actions required of the case manager and record progress to achieve desired outcomes.

Persons who are treated under the *Mental Health Act* 1986 on a Community Treatment Order usually require more active supervision and treatment commensurate with their involuntary status, but this does not preclude involvement of other service providers and possible shared care arrangements. However, in such cases, shared care arrangements must be subject to the requirements of the *Mental Health Act* 1986 and the Community Treatment Order.

Psychosocial rehabilitation forms an important component of all phases of treatment. While the capacity of services to promote independence and quality of life in their consumers may vary according to the availability of other services, case managers should actively consider the purpose for which they see their clients as part of that rehabilitation process.

To maintain realistic caseloads that promote effective and high quality care to consumers, case managers and service managers need to actively examine current contact arrangements at regular reviews of individual clients. The frequency of home visits, the possibility of the person attending the service for appointments, assistance with the use of public transport, involvement of PDSS services to facilitate attendance at appointments and skills development should all be considered. The involvement of family and carers in key aspects of care are also important elements in enabling treatment and care to be delivered efficiently.

Services should have effective linkages with those who provide support and care to consumers with a mental illness such as PDSS day programs or supported residential services. This should include clearly documented strategies for liaison between components of specialist mental health services and primary health care agencies to promote smooth transition of care according to the level of the individual's need including a protocol for joint reviews.

Clinical Review and Case Load Monitoring

Clinical review is an essential component of good practice to ensure that plans are responsive to the changing needs of individuals. Comprehensive reviews to assess treatment progress and outcomes against stated objectives should occur at least six monthly for each consumer. Reviews should identify the need for specialist multidisciplinary input and should involve the consultant psychiatrist who has overall responsibility for the clinical care. Reviews should identify what needs to be achieved for discharge to be considered possible and include explicit strategies for a discharge plan that is regularly evaluated. Where appropriate, reviews should also include external service providers to ensure an effective transfer of care e.g. general practitioners, private psychiatrists and PDSS workers. The outcome and decisions of such reviews should be documented in the clinical record. Services should have systems in place that ensure case lists are current, regularly updated, with dates of all reviews and proposed reviews indicated. Consideration should also be given to whether clinical staff are receiving supervision in using their knowledge and skills to ensure the most effective treatment and care for their clients.

Discharge from Specialist Mental Health Services

Discharge or transfer of care should be considered for Adult Mental Health Service consumers in the following instances:

- Persons approaching 65 years of age.
- Persons no longer resident within the service's catchment area.
- Those who have not received services from the AMHS within the previous three months.
- Those who do not require specialist mental health services. For example, individuals who have been stable for a substantial period and whose psychiatric and psychosocial needs could be provided by a General Practitioner, private psychiatrist or other health care provider.
- Those who require specialist psychiatric services and are compliant with treatment, and whose needs could be provided for by a private psychiatrist or other appropriate service providers.

In exceptional cases it will be appropriate to continue to provide services for some consumers within the above categories. Discharge should occur in close consultation with the consumer and carers wherever possible. This may involve family interviews, and assistance with the gradual transition to the service assuming ongoing treatment and care. Case managers should ensure there is clear information provision and documentation of discharge consultations and arrangements.

It is recognised that at times the community and other service providers have unrealistic expectations of public mental health services, such as an expectation that anyone with a chronic or relapsing mental illness will remain under the care and treatment of specialist public mental health services. These expectations should be consistently and sensitively addressed. It should be emphasised a person may always return to the service should it be clinically indicated. At the point of discharge it is important that consumers and carers are fully informed about how to re-access the service.

Discharge is a crucial transition point and unless carefully managed there is a risk that the individual's ongoing treatment and care may be disrupted adversely. Where a person has had significant or extended contact with the community mental health service, there should be a period of transition to the new service provider. This period should include regular contact between the case manager, the consumer and the service provider to ensure effective engagement and additional support in establishing the new treatment alliance. Once the person no longer requires the input of the community mental health service, discharge can be considered completed and the case formally closed.

Case Closure

Case closure should only occur after the transitional period and successful linking of the individual to the new agency, where this is indicated. The process of case closure should be reviewed by the treating team and agreed with by the responsible consultant psychiatrist.

Case managers should seek consent from the consumer to release appropriate information to family or carers and alternative service providers wherever possible. If the person will not consent to the provision of such information to family or carers, it may be appropriate to release such information to family or the primary carer in the limited circumstances set out in section 120A(3)(ca) *Mental Health Act* 1986.The information may only be released if it is reasonably required for the on-going care of the person to whom it relates, and if it is released to the guardian, family member or primary carer who will be involved in providing that care.

Documentation of the Discharge Process

Each service should have clearly documented discharge protocols. Consultations with the consumer, their family or carer and service providers including actions taken should be clearly documented in the clinical record. Documentation should demonstrate that:

- Discharge planning commenced on admission to the service
- A comprehensive clinical review and consultation with the consumer and carers, has been undertaken prior to discharge.
- The treating team has reviewed the discharge decision.
- Necessary referrals have been undertaken
- Necessary follow up has been undertaken within a reasonable time frame
- Discharge has been formalised in writing with a discharge summary and follow up actions clearly indicated to relevant providers.
- The consumer, carers as indicated, and any relevant service provider have been advised how to re-access the service if necessary in the future, and have been provided with emergency contact numbers.

Self Assessment Tool

The following indicators are provided to assist services in the internal quality monitoring of practices, and form the basis for the Chief Psychiatrist's Clinical Review of mental health services.

- The service has documented policies and procedures on Discharge Planning and Case Closure to guide staff in day to day practice.
- The clinical record shows evidence that discharge planning commenced on the person's admission to the inpatient unit.
- The clinical record demonstrates that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) has been undertaken prior to discharge.
- There is evidence that the discharge decision has been reviewed by the treating team.
- The service ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow-up are, wherever possible, satisfactory to the consumer, their carers and other relevant service providers prior to discharge from the service.
- Necessary follow up has been undertaken within a reasonable time for the consumer's condition.
- Discharge has been formalised in writing.
- The consumer, carers (unless otherwise indicated) and any relevant service provider has been advised on how to re-access the service if necessary in the future, and has been provided with emergency contact numbers.
- The service provides consumers, carers and other agencies involved in ongoing care to identify early warning signs of relapse that indicate the mental health service should be contacted.
- The service attempts to re-engage with consumers who do not adhere to the planned follow-up arrangements.