Tasmanian Mental Health System

Acute Care Team (ACT)

Operational Service Model (OSM)

ACT OSM
For Consultation – Version 9.0 November 2020

STATEWIDE MENTAL HEALTH SERVICES

TASMANIAN HEALTH SERVICE

Tasmanian Government

Contents

1. Executive Summary

The Tasmanian Mental Health Reform Program has created a suite of documents that describe new and revised services to be implemented as part of reforms in Southern Tasmania. The development of these models was undertaken in response to twenty-one recommendations made by the Mental Health Integration Taskforce, which focused on improving integration across mental health services. Establishing the Acute Care Team (ACT) will be a component of eight actions the government has committed to in order to address the Taskforce recommendations.

The development of this operational model has been done in consultation with people living with mental illness, their carers, family and friends, community support organisations, and clinicians.

This Operational Service Model (OSM) outlines the staffing, service hours, and best practice operation for a single Acute Care Team (ACT) for Southern Tasmania. The ACT is designed to cater specifically to individuals not currently active with mental health services or for those who need intense community service provision for a short period of time and cannot access it otherwise. This service differs from current acute care community services in that it will be one consolidated team as opposed to smaller, separate acute response teams servicing three distinct catchments. The ACT is a central component of the Acute Care Stream and will operate within its clinical and operational governance.

At multiple points, this OSM emphasises the need for the ACT to collaborate with the consumer and their family and friends. It also discusses the need to work with community managed organisations to broker in psychosocial supports to address identified needs and of the importance of communicating with external providers when transferring care. It also identifies the need for good communication with General Practitioners and other primary care mental health providers to facilitate the transfer of consumers care to services most appropriate for their ongoing treatment needs after a period of care.

2. Preamble

State-wide Mental Health Services in Tasmania will be provided by services organised into two care streams: **An Acute Care Stream and a Continuing Care Stream.**

The Acute Care Stream (ACS) provides treatment to individuals experiencing moderate to severe mental health symptoms or situational, suicidal distress[1] who have not had any prior or recent contact with mental health services, or are likely to be in need of this intensity of service for short periods of time and are not able to access this treatment in the Continuing Care Stream.

Functions provided as part of the ACS include mental health triage and assessment community-based acute treatment and short-term case management, as well as brief and extended inpatient care. The development of the ACS is designed to provide alternative pathway for acute treatment rather than people accessing services in emergency departments or Acute Mental Health Inpatient Units.

Services performing these functions in the acute care stream in the community include the Acute Care Team (ACT), the Mental Health Homeless Outreach Support Team (MH HOST), the mental health co-responder function. Short-stay inpatient services are provided by the Department of Emergency Medicine Mental Health Short Stay Unit (MHSSU), the Acute

[1] Throughout this document the term mental health needs will refer to both mental health needs and situational, suicidal distress.

Treatment Units (ATUs), and the Mental Health Hospital in The Home Unit (MH HiTH U). Short and longer admissions are provided in the Acute Mental Health Inpatient Units (MHIU). Emergency assessment and care is also provided by the Psychiatric Emergency Nurses (PENs) in the Emergency Department. Other services providing acute care will also be integrated into the ACS structure.

The ACT constitutes a vital component of the ACS. It is a frontline service which responds to acute, emerging mental health needs in the community. Both the accessibility of the ACT and the timeliness of response are important operational factors in the development of community-based mental health systems designed as an alternative to emergency department presentation. By providing an effective community service, the ACT supports other community bed-based acute services (e.g. MH HiTH U and the ATUs) as well as services provided in the Emergency Department.

The Continuing Care Stream (CCS) provides longer-term treatment, case management, and community-based extended care and rehabilitation focused on the personal recovery of individuals requiring assistance in developing both functional skills and contributing to their communities. The CCS may also provide short-term intensive case management for existing clients. Those people who access acute mental health inpatient services will be able to have their rehabilitation and long-term management provided within the continuing care stream.

3. Acute Care Teams (ACT)

The aim of ACT is to provide recovery oriented, trauma-informed community care in the least restrictive environment possible. Although any part of the ACS may become involved in the triage and assessment of a contact or referral, the ACT is specifically designed to provide triage, assessment, and short-term care and treatment in the community. The inclusion of a dedicated triage function into the team highlights that the service is designed to better integrate triage and care functions under the governance of a single team, facilitating a seamless response to community need.

The duration and nature of the interventions is dependent on each individual's circumstances, but the duration is anticipated to be up to 6 weeks. ACT services will be tailored to meet individual need, but will include comprehensive assessment, mental state and/or physical examination, development of treatment plans, and the development of personal safety and recovery plans.

The ACT provides these services to persons with acute care and short-term needs, preferably in the person's own home or in a community setting. ACT service provision occurs in a context which is seen as safe and familiar for the consumer and clinician. This could mean the service could occur in a person's home, a community mental health or health centre, or a general practice. This service is provided in both urban as well as rural and remote areas, in locations mutually agreed upon by all parties. Whilst most of the services will be provided face-to-face, if it is appropriate, some services will be available through online and other virtual means such as videoconferencing.

The ACT model in Southern Tasmania also includes a Mental Health Co-Responder component. This consists of a mental health clinician that can provide rapid, specialist support to Emergency Services, including Police and Ambulance, when responding to acute mental health or behavioural concerns in the community. This function within the team is aimed at providing timely, integrated and coordinated mental health care, improving consumer outcomes, and reducing demand on emergency departments and Emergency Services, where possible.

The outcome of all ACT contacts will be the referral and transfer of care to the most appropriate service that meets the person's ongoing needs. The time people remain engaged with the team will vary. Consequently, the transfer of a person's care (discharge planning), an important part of mental health systems, will occur as early as possible in the person's treatment journey. A primary function of the ACT is the effective and timely facilitation of the transfer of consumers' ongoing care and recovery to those who are identified as best able to undertake this function.

3.1 Service Description

The **key functions** of the ACT are:

- Provide equitable access to centralised, coordinated, and standardised mental health triage and assessment for those contacting mental health services in Southern Tasmania.
- Ensure access to treatment for persons based on urgency and need.
- Prevent or reduce inpatient mental health admissions through assertive short-term community case management.
- Provide treatment and safety planning, including structuring of relapse prevention strategies, for persons with acute mental health needs.
- Provide mental health interventions (including practical assistance) for up to six weeks.
- Facilitate treatment escalation to other parts of the ACS, as required.
- Facilitate referral, transfer of care, and discharge to the CCS and other areas of the mental health system as required.
- In exceptional circumstances, the ACT will assist the CCT in the short-term management of people with acute needs that are co-managed by the CCT.
- Consultation and liaison with other community managed services and primary mental health care providers, to facilitate onward referral, transfer of care, and discharge to the most appropriate service.

3.2 Principles

The principles that guide the ACT (adapted from the RANZCP principles)[2] are:

- **The ACT operate as an integrated and collaborative component of the ACS.**
- **The ACT services must place consumers, their families and their friends at the centre of a person-centered health care system. All three component parts (Consumers, Families and Service Providers) are of equal importance as outlined by the principles of the Triangle of Care concept.**
- **Access to the ACT is founded on the principle of 'every door is the right door', an approach that provides people with, or links them to, appropriate services regardless of where they enter the system of care.**
- **The line between risk avoidance and 'positive' risk taking is not always easy to navigate; to help manage this risk, management and assessment should be an integrated part of evidence-based service design and practice.**
- **A fundamental function of the ACT team is triage. Four fundamental principles governing the triage function are:**

[2] Mental Health for the community. Position statement 73. Accessible here: https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/mental-health-for-the-community. Accessed: 14/10/2020

- **Access:** Specialist services should be accessible 7 days a week and information on how to access services should be proactively provided to communities.
- **Responsiveness:** People requesting help should have their mental health needs assessed by a clinician who should demonstrate a helpful, 'customer-focused' approach.
- **Consistency:** Requests for help should receive a similar response irrespective of client characteristics or the individual clinician responding to the request.
- **Accountability:** There should be a high standard of documentation and accountability for triage, intake decisions, and outcomes. This minimizes the need for a consumer to retell their story.

3.3 Operational Characteristics

The ACT primarily focuses on the acute care needs of newly referred people to the service. This may comprise of triage, assessment, the provision of information and clinical advice, and time-limited interventions of up to six weeks. **The general service characteristics of the ACT are:**

Who: All individuals contacting the service or referred as requiring intensive community mental health care. While the service may not accept all referrals, it will be required to ensure all referrals are triaged and must assist the individual or the referrer to identify the most appropriate point of ongoing care.

What: The ACT is designed to provide triage, assessment, community-based care, and eventual referral for individuals in the community who require intensive case management of their severe mental health issues. The service will be provided for as long as required at this level of intensity, but staff and the ACS should endeavour to safely refer and transition any person who has been accessing services for approximately six weeks in order to ensure there is equity of access for others who require this service.

When: The service is designed to have clinical components which, when considered as a whole, constitute seven day a week provision. This is in addition to existing afterhours service elements designed to assist existing mental health consumers. A new aspect of the model will be the Mental Health Co-Responder Team, designed to improve access to timely and appropriate mental health care for individuals contacting emergency services. The model is also thought to foster improved interagency communication and collaboration.

Where: The ACT will be available for all individuals in Southern Tasmania, irrespective of age or location. Regional resource allocation and triaging requirements may impact the delivery of services. In these instances, the person will be referred to emergency services if at immediate risk. For those people currently or recently involved with the CCS, their contact with the ACT will be for a short time to allow their care to be transferred to the CCT team that regularly provides them with assistance.

How: People can self-refer or contact the ACT in a number of ways: self-presentation, telephone calls, videoconferencing, or written referrals will be accepted. Service contacts will occur largely through face-to-face contact in their home or in an appropriate and safe clinical setting. It is anticipated that the ACT team itself will not routinely conduct assessments and provide treatment at their base; rather they will provide this in a setting most suited to the person's individual needs. Consequently, most of the clinical assessments will occur in the community or in the person's home. A single triage number specific to Southern Tasmania will connect callers to the appropriate service response.

3.4 Service Location

This OSM applies to the ACT in Southern Tasmania. It is anticipated that an ACT service will be considered for the North and North West, taking into account the local factors such as the number of people in each region likely to access services and the size and spread of each region.

3.5 Staffing Profile

The following staffing and roles are identified as integral to a contemporary ACT service in Southern Tasmania:

General Information/Signposting
This role will provide a general community telephone service with specific mental health supports. It will also provide signposting for individuals seeking general information and counselling who may not be suitable for treatment in the acute care stream. When required, the service will also be able to transition consumers to appropriate critical crisis interventions. It is thought that this service, combined with the specialist Triage Officer, will provide consumers with a more seamless entry point into Tasmanian community mental health services as well as assisting in standardising triage and assessment across the Mental Health system.

Triage Officer
The Triage Officer role is a rotational position staffed by senior allied health and nursing staff within the ACT. The role prioritises referrals by performing the triage function while also coordinating staff response to emerging clinical priorities. The Triage Officer represents an important point of communication across the ACT. The Triage Officer function will be staffed over two shifts, from 8:30am-10:00pm.

Consultant Psychiatrist
The Consultant Psychiatrist provides overarching clinical governance and medical management of the ACT. The consultant is expected to lead the ACT providing treatment and care for people with a wide range of acute care needs of varying complexity and severity. The consultant will work with the team to formulate treatment plans and to facilitate the transfer of care to other providers. The ACT consultant will be supported by medical staff from services collocated with the ACT, such as the MH HiTH U and MH HOST.

Team Leader
The Team Leader holds the operational responsibility for the functioning of the ACT team (inclusive of the general information and triage functions) in addition to the MH HiTH MH HOST and MH HiTH U services. This includes line management, rostering, recruitment, performance management, and mandatory training.

Clinical Lead
The Clinical Lead will be responsible for the clinical governance within the team in accordance with an existing clinical governance framework. The clinical lead will provide high-level consultation and advice to clinicians to ensure a high-quality mental health service.

Nursing and allied health
Nursing and allied health shift workers will provide care for individuals accepted into the service. It is also expected that both nursing staff and allied health staff will be expected to undertake some duties specific to their professional discipline, providing specialist advice and support in relation to specific therapeutic interventions.

Mental Health Clinical Co-responders

The Mental Health Clinical Co-responders are embedded within the ACT and staffing will be rostered. These clinicians will work with Emergency Services to provide onsite clinical assessment of a person's mental health, advice regarding de-escalation strategies, and advice regarding referral and transport options. The mental health clinical co-responders may also be tasked with the development of management plans for people who are frequently in contact with emergency services.

Peer Workforce

Peer Support Workers provide a unique lived expertise that gives the team a comprehensive understanding of the consumer's needs. Peer support workers fulfil a fundamental role which is not usually provided by any other discipline. The role is also vital because the expertise is central to the recovery of the users of the service. Recognition of the central role of peer support workers within the ACT emphasises the philosophy of ACS to embed recovery principles into routine service provision.

Administrative support

The size of the team, the associated caseload, and the need to communicate with various other organisations will require dedicated administrative support. This administrative support may also be tasked with supporting functions within the ACS which are collocated with the ACT.

3.6 Hours of Operation and Work Patterns

- ACT will provide a service seven days a week. This will include a multidisciplinary team on duty each day with nursing staff.
- The following table outlines the responsibilities for distinct functions over the period of operation, aligned to a proposed shift pattern.

Shift Pattern	Information	Triage	Assessment & Treatment
8:30am-5:00pm	General Information/ Signposting	Dedicated Triage Officer	-ACT Case Management
2:00pm-10:00pm	General Information/ Signposting	Dedicated Triage Officer	-Extended hours ACT Case Management -Mental Health Co-Response

- The ACT team will operate from 08:30am to 10:00pm daily.
- The ACT team will work in two eight-hour shifts:
    - Morning: 8:30am – 5:00pm
    - Afternoon: 2:00pm – 10:00pm
- Provision of staffing between 08:30am-05:00pm will allow for at least three urgent mobile call out responses across the region at any given time **and** staffing of separate triage and signposting functions.
- Crisis presentations/contacts outside of ACT extended hours may be received through either the triage function or from emergency services, both of which may be referred to the Mental Health Co-Response clinicians or downgraded to allow for next day follow up.
- Requests for response after the stated business hours will be escalated to the appropriate service.

3.7 Governance

- A system of operational and clinical governance will be developed within the ACS which will outline operational and clinical responsibilities across all shifts and contingencies.
- Responsibilities of those tasked with operational governance are to ensure the team operates in accordance with the ACT operational service model as well as other day to day management of staff and location. Other tasks may include staff recruitment, retention, monitoring staff training, and budgetary management. The team leader will be tasked with the operational governance of the service during normal business hours.
- Responsibilities of those providing clinical governance to the ACT team are to monitor and safeguard patient safety. This includes ensuring risk management processes are maintained, providing professional development opportunities and maintaining and improving standards of clinical care. The consultant has the responsibility for the clinical governance of the team during normal business hours, with a system to escalate clinical governance requirements within the ACS to be developed.

3.8 Legislative Framework

The following documents constitute mental health-specific legislative frameworks and National Standards that each employee of the Tasmanian State-wide Mental Health Service must abide by:

- Mental Health Act 2013.
- National Standards for Mental Health Services;
- National Safety and Quality Health Service Standards;
- Guardianship and Administration Act 1995;
- Criminal Justice (Mental Impairment) Act 1999;
- Children, Young Persons and their Families Act 1997;
- Personal Information Protection Act 2004;
- Carer Recognition Act 2010.

3.9 Evaluation

The following performance indicators will be used to monitor and evaluate the ACT team across five domains. Additional KPIs surrounding the general information, signposting, and triage function will be developed as that aspect of the service matures.

Domain	Performance Indicators
Fidelity to the operational service model	•**(Monthly)** Number of consumers per clinician (15-20, acknowledging varying clinical complexity and care requirements) •**(Monthly)** Percentage of people seen out of total caseload •**(Quarterly)** Percentage of consumers who are reviewed in an MDT over the course of 91 days •**(Quarterly)** An average of 1.25 hours of direct clinical contact every week for a 6-week period •**(Quarterly)** An average of two treatment days per week ACT care period per consumer •**(Quarterly)** Approximately 275 hours of direct clinical contact per case load per single FTE over a three-month period (case load of 15-20 per FTE clinician x 12 weeks)

Domain	Performance Indicators
	•**(Quarterly) Percentage of** Re-referrals to ACT within 3 months of discharge •**(Quarterly)** Number of consumers discharged or transferred from ACT at 4-, 6- and 12-weeks
Safety & Quality	•**(Quarterly)** Percentage of consumers with completed triage and assessment documentation •**(Quarterly)** Completion of NOCC measures for ACT consumers every 91 days/as required •**(Quarterly)** Percentage of consumers with completed CwP assessments recorded and in the clinical record •**(Quarterly)** Percentage of consumers with completed CwP Safety Plans recorded and in the clinical record
Patient Outcomes	• Change in HoNOS Scores • Change in RAS-DS Scores • Review of consumer/carer satisfaction measures which will include a quantitative self-report approach and written questionnaire, specifically the YES and CES survey.
Vertical Integration	•**(Quarterly)** Percentage of individuals with first/recent contact with services who present to the ACT •**(Quarterly)** Proportion of ACT clients who are seen by an ACT clinician within seven days of admission to an inpatient unit •**(Quarterly)** Proportion of ACT clients who present to ED/other emergency services while a community mental health service client •**(Quarterly)** Proportion of ACT clients who are admitted to an inpatient unit within seven days of contact
Horizontal Integration	•**(Quarterly)** Proportion of referrals from CMOs •**(Quarterly)** Proportion of referrals to CMOs linked to discharge planning •**(Quarterly)** Proportion of referrals from CMOs identified as appropriate for the service •**(Quarterly)** Proportion of individuals managed in the ACT who are jointly active with community based mental health services and CMOs •**(Quarterly)** Proportion of individuals transferred to CMO/external providers •**(Quarterly)** Proportion of individuals transferred to CMO/external providers who have a record of engagement with the intended CMO provider •**(Quarterly)** Proportion of individuals transferred to CMO/external providers who have a record of engagement with any CMO provider

4. Functions of the service

The following sections set out common processes to be undertaken in the ACT team. The sections are listed in their intended procedural order, starting with the receival of triage and culminating in discharge, although not all people who access ACT will need to participate in all of the functions outlined.

4.1 Receival of Referral and Triage

- ACT receives referrals from all parts of the mental health system (including self-referrals) via a number of different mediums (phone, in writing, telehealth, through standardised clinical assessment form).

- In the initial phases of referral receival and triage, as much information as possible should be gathered to make the triage assessment detailed and accurate.
- The initial triage assessment can be completed by the Triage Officer by telephone/videoconference; however, face to face consultation is always preferred.
- All clinical documentation should be completed in accordance with operational procedures surrounding triage. An underpinning of the Acute Care Stream will be that common triage processes and documentation will be used across all functions within the stream.
- Most referrals received by the ACT team will be triaged by the Triage Officer. If the Triage Officer is unavailable, any clinical team member may initiate the triage process.
- The outcome of the triage process will inform whether the individual will receive a more comprehensive face-to-face initial mental health assessment (see the section on assessment below) or may be referred onto other services identified to be more appropriate for their needs, dependent on the identified urgency.
- Triage (and assessments) often occur outside of a clinical setting and individuals may request help and support from any member of the ACT team in almost any situation and setting that the staff members determine safe and appropriate. The triage process is the same, but in such situations, staff must determine the level of presenting risk to the individual and mental health staff and decide whether the conversation surrounding triage can safely take place.
- The purpose of the triage process is to gather information to identify the level of acuity, risk and the needs of the person. Key areas to be discussed while conducting a triage assessment are:
  - Reason for referral
  - Source of referral/information accompanying referral
  - Communication Issues
  - History
  - Medical needs
  - Current treatments
  - Drug and alcohol use
  - Current functioning and supports
  - Forensic and legal status
  - Overall clinical impression
  - Level of acuity
  - Risk
- When a referral is received by the ACT of current or recently discharged (in the past 90 days), consumers accessing the continuing care stream can be referred directly to the relevant Continuing Care Team (CCT).
- Individuals triaged as low urgency of need and who meet the criteria for CCT may be referred to CCT services directly (please refer to Section 4.8-Transfer of Care).
- All referrals will be discussed at an intake meeting for follow up by the ACT. However, where an urgent mental health assessment is required, the Triage Officer will liaise directly with ACT clinicians to enact this and will not wait for the MDT or intake meeting.
- In all cases, the relevant triage assessment documentation should be completed and placed in the medical record or stored electronically as per the defined process.

4.2 Assessment

Conducting the Assessment

- All persons triaged by the Triage Officer (or ACT team member) and found to be appropriate and suitable for care by the ACT must receive a comprehensive mental health assessment.
- The assessment should be conducted at the first point of contact or as early as possible in the treatment journey. The assessment is to be documented using the relevant clinical documentation form.
- A comprehensive mental health assessment is a holistic, person-centred approach to establishing an individual's mental health status, the formulation of a clinical impression and the development of a collaborative mental health treatment plan.
- The initial ACT assessment may be the first face to face consultation with the consumer and their supports. This interaction provides the ACT with the opportunity for the person to tell their story to assist the ACT team to identify aspects of care relevant to them.
- The following topic areas need to be considered in the development of comprehensive mental health assessments:
  - Mental health status
  - Presenting problem (in their own words)
  - Treatment History
  - General Health
  - Personal Strengths and goals
  - Natural supports
  - Social Skills
  - Safety Planning
  - Rights, Advocacy, and legal needs
  - Goals
  - Initial assessment of need
  - Alcohol and drug use
  - Physical/Oral health needs
  - Risk assessment (discussed in more detail below)

- Other aspects to consider in the development of an appropriate mental health assessment are:
  - Input from family and other natural supports should be integrated into the assessment where available and appropriate to do so. Options for support people to be present if appropriate and specific consideration of family circumstances is also required, with emphasis on children and dependents. The outcome of any assessment should be communicated to the consumer, carers and other providers as appropriate.
  - A Comprehensive Mental Health Assessment will be tailored and developmentally appropriate to the age of the person.
  - Where consumers identify specific needs, to ensure effective communication, the ACT will engage the assistance of appropriate services.
- Assessments can and should occur at multiple points in the treatment journey. When required, assessments should be timely and reflect the needs of consumers and their families and friends.

Outcome of the Assessment

- **If an individual is identified as suitable for the ACT based on their triage and assessment,**
  - the accompanying triage and assessment documentation will be presented at the next available MDT by the assessing clinician, ideally no longer than 24 hours from when the assessment was made.
  - a case manager will be allocated based on local processes and a full clinical file will be created. Where possible, the same clinician who conducted the assessment should be the clinical case manager to assist in the continuity of care.
  - the clinical case manager and/or the clinician who conducted the assessment should briefly present the consumer to the MDT and discuss immediate treatment priorities and the proposed treatment plan.
- **If, after a comprehensive assessment, it is decided that the person's care and treatment needs are best met outside the ACT,**
  - options outside of the ACT should be considered by the MDT, dependent on consumers' needs, preferences, urgency and availability of alternative treatment options All persons not receiving ongoing mental health care within the ACT are to be referred to an appropriate service matched to their needs.
  - the ACT will follow the steps surrounding transitioning of care outlined in section 6 when referring individuals to more appropriate services.

4.3 Risk Assessment

- Assessing risk in conjunction with consumers is an integral part of clinical practice and is therefore an integral part of any assessment. Risk should be assessed at every contact with an individual.
- ACT clinicians are required to conduct and document a risk assessment in the following circumstances at a minimum, acknowledging that there are many circumstances which may warrant renewed and ongoing assessment of risk. The minimum requirements are:
  - upon initial assessment (or first contact if the individual has already been assessed)
  - upon transfer of case management responsibility (within the team)
  - upon transfer of care to an external provider (often at multiple points, including referral, formal transfer of care, and discharge)
  - any other time in which a change in clinical presentation and or significant life circumstances is noted
- A thorough risk assessment will assess:
  - risk of harm to self (assessing risk of suicide to be considered in a separate section below)
  - risk of harm to others
  - vulnerability risks
  - risk of not engaging with service
  - risks associated with discharge planning

- A thorough risk assessment will lead to:

  - A clearly formulated risk management and safety plan, understood by the consumer, their family and friends, and relevant service providers.

- a management and safety plan informed by and compliant with current guidelines, procedures, and protocols relating to risks to persons, staff and community safety.
- all service providers, family, friends and significant others being engaged in the risk assessment process and informed of the outcomes.
- Consideration of child safety issues in accordance with mandatory requirements, policy and guidelines on the management of abuse and neglect of children and young people (0-18 years).
- Practice in accordance with the risks identified. This includes selecting the place and time the clinician interacts with the consumer. While the care coordinator should visit with the consumer at a location identified as safe, there may be times when an additional staff member is preferred due to the risks identified at that point in time.

4.4 Recognising and responding to suicidal distress

- Improving the way mental health services in Tasmania identify and mitigate suicidal or other forms of distress is a core component of mental health reforms.
- In order to improve the approach, a common contemporary approach to assessing, understanding and responding to suicidal distress and risk will be adopted. Connecting with People (CwP) offers a new narrative that moves away from the characterisation of risk as the primary goal, and instead places a greater focus upon compassion, use of a common language to communicate, and safeguarding and mitigation through the universal development of personal safety plans as a central feature of the system.
- As part of the organisational commitment to changing the narrative surrounding suicidal distress, all clinicians within the acute and continuing care streams will be trained in the how to respond to people in suicidal distress using the CwP approach.
- Clinicians will also be skilled in how to co-develop safety plans. The presence and content of safety plans will also be addressed as part of future clinical documentation audits.
- Clinicians identified as likely first responders to individuals in distress (this includes members of the ACT team such as the Triage Officer) may also be trained in the Chronological Assessment of Suicidal Events (CASE) approach , which is designed to assist in the elicitation of suicidal ideation, planning and treatment in busy or difficult clinical environments.
- Clinicians will be expected to practice in accordance with relevant national and international best practice guidelines and the training they have received when responding to individuals in suicidal distress.

4.5 Intake (Acceptance into the service)

- ACT services are provided to all people in or entering the community who experience severe mental health issues and who would benefit from an acute community based acute care service.
- The choice to accept any individual is based on the outcome of the triage and assessment processes outlined in sections 4.1 to 4.4 above. Common examples of individuals suitable for the ACT service include:

  - persons experiencing a situational crisis or distress.

- persons experiencing severe mental health symptoms with accompanying significant levels of disturbance, psychosocial disability, and/or reduced functioning.
- persons with significant mental health concerns and co-occurring functional difficulties that require coordination of care and support across multiple agencies and supports.
- persons requiring brief intense and assertive mental health support.
- persons with significant mental health concerns that would benefit from a multi-disciplinary team due to the intensive or complex nature of care required.

- ACT will work collaboratively with specialist services as required to provide care and support to individuals based on their specific needs, such as adolescents, older persons, CALD, Aboriginal, and LGBTIQ+ populations.
- In situations where more appropriate care can be provided by specialist teams as identified prior to commencing treatment, the ACT can initiate a referral to the other services. However, the ACT remains responsible for the ongoing care of that person until the referral has been accepted and a transfer for care/shared care arrangements have been completed.

4.6 Treatment

- Individuals receiving treatment from the ACT will be supported to engage in and access a range of evidence-based therapeutic interventions to optimise their recovery. The characteristics of these services will vary based on individual preference and clinical need.
- Clinical interventions offered, provided, and declined will always be documented.
- Individuals will be involved in the development of their care and treatment plans, safety plans, recovery plans and supported in their treatment choices. These processes are known to assist them in meeting their goals and treatment needs in accordance with their values.
- The person's stage of recovery and phase of care will be taken into account in supporting their choice of care. Approaches to address relapse prevention will also be discussed.
- Wherever possible, the person's family, friends and natural support networks will be encouraged to be part of any recovery planning. The concept of recognising them as equal partners in care is fundamental to the new system.
- Care planning and interventions will be developed with the consumers and identified others and form an integral part of the MDT process. Cases can be presented and discussed daily at MDTs in response to changes to risk, crisis presentations, or increased need. All decisions made in the MDT will be recorded in the clinical record.
- Frequency of care should be escalated as required, with increasing care requirements to be discussed with the team.
- Clinical interventions will be offered through a range of methods in the least restrictive setting that balances the persons autonomy with their safety needs:

    - Clinicians will support people in developing or regaining independent living skills in the community as the person transitions through their recovery stages. The extent and type of support will be determined by their own goals.
    - Key principles such as privacy, dignity, choice, anti-discrimination and confidentiality are recognised, respected and maintained in all treatment planning and decision making.
    - The ACT will focus on strengths, connectedness and actively fostering hope, empowerment, choice and responsibility.

- All aspects of care will support the development of collaborative relationships between individuals, their carer/significant others and service providers.

- The service recognises and acknowledges the impact of trauma alongside awareness and sensitivity to its dynamics in all aspects of service delivery.

4.7 Discharge Planning

- Discharge planning is one of the most important aspects of mental health care and should be initiated as early as possible in an individual's treatment journey, ideally at admission.
- Decisions about the timing of a discharge should occur with all services involved in that person's care. It should include careful evaluation of the risks and benefits of the discharge from SMHS, including longitudinal history and prognosis. The person, their family and friends and other stakeholders should be consulted about the timing of the decision.
- Discharge planning should be conducted with multiple aims in mind, namely:
  - Discussion and familiarisation of the consumer with the elements of the envisaged discharge, including times, locations, and purpose.
  - Affirmation of treatment goals and a recovery plan, together with a safety plan and management recommendations.
  - Identification and discussion of early warning signs of relapse and risks.
  - Development of medical and non-medical strategies for managing early warning signs.
  - Clarification and confirmation of the person's current and ongoing involvement with other agencies or service providers.
  - Confirmation and recording of contact details of case managers, family, friends and advocates.
  - Development of a brief statement of the person and their family and friend's knowledge of the condition and the management, including treatment adherence and self-management.
  - Familiarisation of consumers, family and friends, and designated contacts on how and where to refer in situations of mental health crisis or to obtain a second opinion (includes instruction on how to re-enter services).
- Staff will ensure that these topics have been discussed and outlined with both the individual and their family and friends prior to engaging in a discussion surrounding discharge planning.
- Some common reasons for discharge from the ACT include:
  - The person is no longer resident within the regional area.
  - The person no longer requires specialist mental health services. For example, individuals who have been stable for a substantial period and whose mental health and psychosocial needs could be provided by a GP, private psychiatrist or other health care provider.
  - The person requires specialist mental health services and is compliant with treatment, and whose needs could be provided for by a private psychiatrist or other appropriate service providers.
- If the person's needs appear to change post discharge and their existing plan becomes inappropriate to their needs, assistance or advice can be sought by an external provider from the ACT.

4.8 Referral to other services

- A referral occurs in situations where it is identified and agreed that an individual is able to receive more specialised or more suitable mental health treatment from another practitioner and/or service (see Section 4.7 above).
- The referral process should not be initiated until the relevant aspects of discharge planning (see Section 4.7 above) have been addressed and discussed with the individual being treated as well as family and carers and the team.
- The service to whom an individual is to be referred should be identified and informed of the intent of the referral early in the process and should ideally receive updates surrounding its progress.
- Processes and procedures which set out the required documentation and information to facilitate these transfers will be developed for the acute and continuing care streams and the interactions between both.
- Common referral destinations from the ACT to state-wide mental health service functions are listed below:
  - Mental Health Inpatient Units (MHIU)
  - Acute Treatment Units (ATUs)
  - CCTs
  - Long term rehabilitation services
- Common referral destinations from the ACT to non-governmental community services are listed below (these are illustrative, and the list is not exhaustive). Processes and procedures which set out the required documentation and information to facilitate these transfers will be developed for the acute and continuing care streams and the interactions between both streams, non-governmental organisations and private providers.
  - CMOs and other community services
  - GPs and other primary care clinicians

4.8 Transfer of Care

- The desired outcome of any mental health transfer of care is a seamless transfer of care and clinical responsibility with as little disruption as possible to a consumer's healthcare, support, and recovery journey.
- It is the responsibility of the referring team to provide recent, relevant clinical documentation and a verbal handover to the receiving team or clinician, at the time of referral or transfer. This ensures early engagement, receipt of critical written documentation by the receiving service and continuity of care.
- Referrals and transfers out of area require recent, relevant clinical documentation to be provided to the receiving service, with a verbal handover. Whenever possible, a handover conducted in person between representatives of both parties, Inclusive of the consumer and family and friends, should be undertaken.
- All transfers of care will be discussed with the team at the MDT and documented in the clinical file.
- A documented handover will be provided on every transfer/discharge occasion.

- Individuals and their family and friends will actively participate in the transfer/discharge procedures.

4.9 Discharge

- Discharge should only be initiated once the referral and transfer of care has been verified by the receiving party and the care needs of the consumer have been met by an organisation seen to be able to provide an appropriate standard of care.
- The receiving service and any other parties should be informed of the change in clinical responsibilities (e.g. change in care coordinator).
- Where appropriate (where contact does not increase confusion and compromise clinical boundaries), the consumer should be followed up in order to ensure that the care transfer has been successful.
- Discharge processes should include ensuring that all relevant information and materials have been passed onto the designated receiving service/clinician and receipt of this documentation is then confirmed and documented in the clinical file.
- All clinical documentation should be reviewed and updated to reflect changes in the care arrangements, including documenting follow up/attempts at follow up post discharge, and any relevant contact information for the ongoing service.
- All discharges will be discussed at MDT meetings and documented in the clinical file.
- The clinical file should be finalized and any administrative processes, outlined in procedure documentation, completed. This also includes the completion of routine outcome measures.

5. Protocols and Procedures

- Tasmanian Health Service and Statewide Mental Health Services have a suite of procedures and protocols that are relevant to aspects of service provisioning outlined in this document.
- Some policies and procedures will be aligned to and made specific to the functioning of the ACT. Others will be generalisable to the ACS. Still others will be applicable to all clinical practice across the state-wide mental health service.

6. Staff Education and Training

- Staff will be provided with mandatory training, clinical supervision, and continuing education opportunities to ensure that they are able to deliver the ACT service in a contemporary manner as outlined in this document and accompanying policies and procedures.
- All new ACT staff will be provided with THS, State-wide Mental Health Services, and local orientation as a required element of their induction.
- In addition, specialist training content and requirements will be developed across care streams, tailored to individual treatment settings (inpatient and community).
- The ACS will have access to specialised clinical education and clinical supervision resources. Education and training will focus on improving clinical skills as well as introducing contemporary training related to implementation and service evaluation. The THS values the development and delivery of training to the THS employees.
- Where possible and applicable, training will be made available to service partners to improve communication and interoperability of services (e.g. CMOs, GPs).

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