

COMMUNITY HEALTH SERVICES

# RESOURCE MANUAL

## ASSERTIVE CASE MANAGEMENT

*A Proactive Approach*

January, 2008  
Version 1

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# Section I

## Background Context and Discussion

### Introduction

Community Mental Health Services (CMHS) are a core component of an efficient and effective Mental Health Service in Tasmania and deliver acute, crisis, continuing care, rehabilitation and intensive support services across all regions of the state. A comprehensive, integrated model of community service has been adopted and is delivered through multidisciplinary teams across regions focusing on three key target groups, Child and Adolescent, Adult, and Older Persons Mental Health Services.

*Assertive case management* is a central component of the Tasmanian Mental Health Service Model of Care and is a shared function of all clinicians within CMHS. This resource has been developed to ensure a consistent approach to *assertive case management* within an integrated service model. It will clarify how *assertive case management* is delivered within multidisciplinary teams (MDT) and at what point case management commences and ends.

It is important to note that this resource outlines the core principles of this approach, and it is recognized that there will be some variations within the three target groups in its application. Additional resources are available within each of these areas which detail its operation at this level

### Tasmanian Mental Health Service Principles

The Tasmanian Mental Health Services Strategic Plan Vision is “**partners towards recovery**”.

The following Service principles have been identified within the strategic plan and form the foundation of all services provided by, and through MHS. They are regarded as essential to ensure a high standard of treatment, care and information, regardless of which component of Mental Health Services is accessed. Whilst *assertive case management* is listed as one of the foundation principles other principles are applied in the practice of *assertive case management*. All principles are listed below:

Single point accountability	Least restrictive
Customer focused	Evidenced based best practice and outcomes measures
Partnerships	Population based planning and service delivery
Comprehensive service	Early intervention and <i>assertive case management</i>
Integrated and standardized	Skilled and supported multidisciplinary workforce
Mainstreamed <sup>1</sup>	

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<sup>1</sup> *Tasmanian Mental Health Services Strategic Plan 2006-2011*, Mental Health Service, Department of Health and Human Services, Hobart, 2006, p 3.

It is important these principles are understood and embedded into practice by case managers to inform decisions in relation to care provided and to ensure they are carried through in interactions with consumers, carers, other service providers and the community.

## **DHHS Agency Direction and National Framework**

Whilst the assertive case management proactive approach incorporates Tasmanian Mental Health Service principles it also reflects broader agency direction and the National Mental Health plan as outlined in the following section.

### **Collaboration Strategy**

The broader sector of health in Tasmania –‘Department of Health and Human Services’ (DHHS) has developed an agency ‘*Collaboration Strategy*’ (2004) with underlying principles to achieve the best outcomes for consumers, these include:

- Work together in a spirit of cooperation
- Intervene as early as practicable
- Keep the consumer and their world at the centre
- Find solutions that are fair, creative and affordable
- Design understandable process

Tasmanian Mental Health Services have reflected these principles in its Mental Health Services Strategic Plan 2006 -2011 through principles such as recovery focused, customer focused, early intervention and partnership with others to improve health outcomes for our consumers. These will be delivered through an *assertive case management* model.

### **Recovery Orientation**

*Assertive case management* embraces National Mental Health Standards and the principles of care from the National Mental Health Plan 2003-2008, which promotes a framework within Mental Health Services that supports recovery.

Recovery orientation is provided through:

- Accessible care to all consumers based upon least restrictive and population based needs and approaches
- Services responsive to consumer, family and carer needs
- Care delivered by skilled ethical professionals
- Continuity of care and identifiable, single points of contact and accountability

- A coordinated approach<sup>2</sup>

Recovery is fundamental to the MHS model of care. Every person has the right to, and MHS have an obligation to ensure every effort is made to focus our service, and the consumer's goals on recovery.

The *assertive case management* model draws significantly on the strengths model of case management and strongly supports a 'recovery orientation' to care.

'Recovery is the journey towards a new and valued sense of identity, role and purpose outside the parameters of mental illness: and living well despite limitations resulting from illness, its treatment, and personal and environmental conditions.'<sup>3</sup>

'A recovery model provides holistic treatment and care within an active and assertive partnership between consumers, carers and the necessary support agencies, delivering goal orientated and assertive care and treatment. It focuses on potential and strengths not deficits, and restores hope and optimism for consumers with mental illness, for their carers and for the service providers who work with them.'<sup>4</sup>

Sharing the responsibility for recovery, self determination and social connectedness are key principles in case management. These principles are achieved through a collaborative approach to Individual Service Plans (ISPs) where:

- The case manager/consumer relationship is primary and essentially based on collaboration, mutuality and partnership
- Interventions are based on the principles of consumer self-determination
- Goals and targets are selected by the consumer
- All steps, no matter how small that lead towards a consumers recovery, are acknowledged
- The community is viewed as an oasis of potential resources for the consumer where other resources are actively mobilized.

### **Needs of Children of a Parent with Mental Illness**

At a national and state level the needs of children of a parent with mental illness, have been recognized via the COPMI framework. In Tasmania under the 'Kids in Mind Tasmania' project a set of guidelines for responding to the needs of such children by clinicians is under development. The *assertive case management* model supports this approach to care, and has incorporated the guidelines (in draft) into the model at intake where parental status and children's needs are identified. The COPMI guidelines outline a process for the assessment and development of a plan to meet children's need in collaboration with the family. A 'Family Care Plan'

<sup>2</sup> *National Health Plan 2003 – 2008*, Commonwealth of Australia, Australian Health Minister, Australian Government, Canberra, 2003, p 21.

<sup>3</sup> Anthony WA., (2000)'Recovery from mental illness: The guiding vision of the mental health service system in the 1990's', *Psychiatric Rehabilitation Journal* 16(4), p 159.

<sup>4</sup> *Tasmanian Mental Health Services Strategic Plan 2006-2011*, Mental Health Service, Department of Health and Human Services, State of Tasmania, February 2006, p 9.

should be completed for all consumers with parental responsibilities, by the case manager.<sup>5</sup>

### **Reducing Suicide and Deliberate Self Harm in Mental Health Services**

National Safety Priorities in mental health have now been identified. The reduction of suicide and deliberate self harm in Mental Health Services is one of four priority areas to be targeted. The *assertive case management* model addresses this priority through several mechanisms such as mandatory risk assessment, proactive and assertive follow up, a focus on outreach as well and in-reach (inpatient) service provision and most importantly a mechanism for continuity of care.<sup>6</sup>

### **Population and Health Priorities, focus on Chronic Disease**

The DHHS Population Health Division have developed priorities for population health, which focus on the prevention and management of chronic disease for conditions such as diabetes and heart disease, and areas such as nutrition and physical morbidity. Consumers of Mental Health Services have higher rates of physical morbidity than the general population. The *assertive case management* model considers these needs as part of the development of an ISP. Health needs are assessed at intake, monitored and reviewed, and when required, consumers are assisted to access health services and engage in a range of healthy lifestyle activities.<sup>7</sup>

## **What is *assertive case management*: a proactive and collaborative model?**

Understanding case management and its application in an assertive and proactive approach in Mental Health Services requires a breakdown of the various components of this model.

### **Case Management**

‘A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote cost-effective outcomes.’<sup>8</sup>

### **Case Managers**

An identified and accessible staff member who is responsible for coordinating the treatment and support provided to individual consumers and their carers. This includes a range of assessments and interventions with the aim of fostering

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<sup>5</sup> Children of Parents with Mental Illness, Mental Health Service, Department of Health and Human Services, draft version.

<sup>6</sup> *National Safety Priorities in Mental Health: A National Plan for Reducing Harm*, Health Priorities and Suicide prevention Branch, Department of Health and Ageing, Commonwealth of Australian, Canberra.2005, p 13.

<sup>7</sup> Tasmanian Department of Health and Human Services 2005, ‘Population and Health Priorities’, <http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=5461>

<sup>8</sup> ‘The Case Management Society of Australia’, *National Standards of Practice for Case Management 1998*, Melbourne, p 16.

independence and improving quality of life for consumers.<sup>9</sup>

### **Proactive**

A proactive style of case management promotes engagement of reluctant consumers, close follow up for new fragile consumers and responsive management of consumers with enduring mental illness.<sup>10</sup>

### **Assertive**

R. Lakeman describes assertiveness as:

‘...neither passively neglecting the individual with a mental illness nor aggressively riding rough shod over his or her human rights to enforce treatment.’<sup>11</sup>

It means not allowing the person to fall through the cracks and knowing when to stand by. This is not something which is easily prescribed and requires skills in engagement, negotiation, knowledge of good mental health practices and ethical sensitivity. Establishing long term relationships based on respect fosters engagement and collaboration’.

### **Community**

*Assertive case management* is about the location of care within the consumer’s community as this is acknowledged as the source of natural support and sustenance for the person. *Assertive case management* aims to develop the capacity of families, generic health services and communities to provide care and support to consumers and their families.

### **Treatment**

Treatment entails not only medical treatment for mental illness but also extends to care in the broader sense. It involves building on the strengths of the individual and the community to assist in the resolution of everyday problems. The focus is on growth, recovery and developing a positive outlook. Clear treatment goals (negotiated with the person) provide the context for interactions with the case manager and are achieved with appropriate input from the broader multidisciplinary team.

The Tasmanian Model of *assertive case management* adopts the traditional practices usually reserved for the care of consumers with enduring mental illness and intensive needs. It applies these practices to all consumers of the service receiving case management. This is not to say all clients will require the same type or intensity of care, however, all will be provided with assertive follow up to promote active engagement with the services for the best outcomes for each consumer entering our service.

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<sup>9</sup> ‘National Standards for Mental Health Services’, *Commonwealth of Australia 1997*, Australian Government, Canberra, p 50.

<sup>10</sup> McGorry P., Killackey E., Elkins K., Lambert M., Lambert T., ‘*Summary Australian and New Zealand Clinical Practice Guidelines for the Treatment of Schizophrenia: 2003 Australasian Psychiatry Vol 11. No 2. pg 138-144*

<sup>11</sup> Lakeman R., ‘Towards Assertive Community Care’, *The North Queensland Sub-branch of the Australian and New Zealand College of Mental Health Nurses Winter Symposium, 2001*, p. 16.

For the individual consumer *assertive case management* provides a single point of access to a case manager and a multidisciplinary team with specialist skills in mental health care. The consumer can expect the case manager to coordinate their care. The case manager will ensure continuity across the service through community outreach and, if required local hospital or GP in reach. Consumers can also expect case managers to be proactive in providing treatment and support to meet their needs, in a timely and effective manner.

### **Evidence based practice & assertive case management**

It is important to recognize that evidence based treatment approaches for particular types of disorders may conflict with assertive case management practices. One such example is dialectical behavior therapy, one of the empirically validated treatments for borderline personality disorder. This treatment aims to promote client responsibility and autonomy while offering assistance to develop the skills required. The response of the clinician to therapy interfering behaviors by the client (e.g. non-attendance at scheduled therapy appointments) is made explicit in this therapy in the form of a contract at the outset of treatment. The assessed current capacity of the client informs decision making. The client may at times choose to not contact the clinician and the clinician, in consultation with the multidisciplinary team, may decide that evidence based practice indicates that they await contact from the client. In such situations the client is assessed as being able to rationally make this decision and is aware of the contract regarding non-attendance. To assertively follow-up such a client in this situation would seriously undermine the treatment goals of autonomy and responsibility. In situations where assertive case management principles are contrary to evidence based best practice, evidence based best practice is paramount, and as such will be endorsed by the multidisciplinary team.

### **Features of an *assertive case management* model<sup>12</sup>**

The following features have been adopted from those identified by Parkside Community Mental Health Service – Burnie, Tasmania (unpublished) and those described by Dowling et al.

- ❑ Consumer, carer and family focused and embraces active participation
- ❑ Assertive and proactive engagement and follow-up
- ❑ Regular mental status and risk assessments
- ❑ The establishment and maintenance of an ISP including relapse prevention and discharge planning strategies
- ❑ Appreciation of both external and internal pressures on motives, strengths and values of the consumer
- ❑ Ongoing, specialist/ professional training and supervision
- ❑ Evidence-based bio-psycho-social-cultural interventions
- ❑ Psycho-education for consumers and relevant others
- ❑ Timely service capacity including the ability to respond rapidly and effectively to escalating acuity and crises

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<sup>12</sup> (RM Dowling, RM, Fossey E., Meadows G., Purtell C., 'Case management', in *Mental Health in Australia: Collaborative Community Practice*, Edited by Meadow G and Singh B, Oxford University Press, 2001, pg 204.)



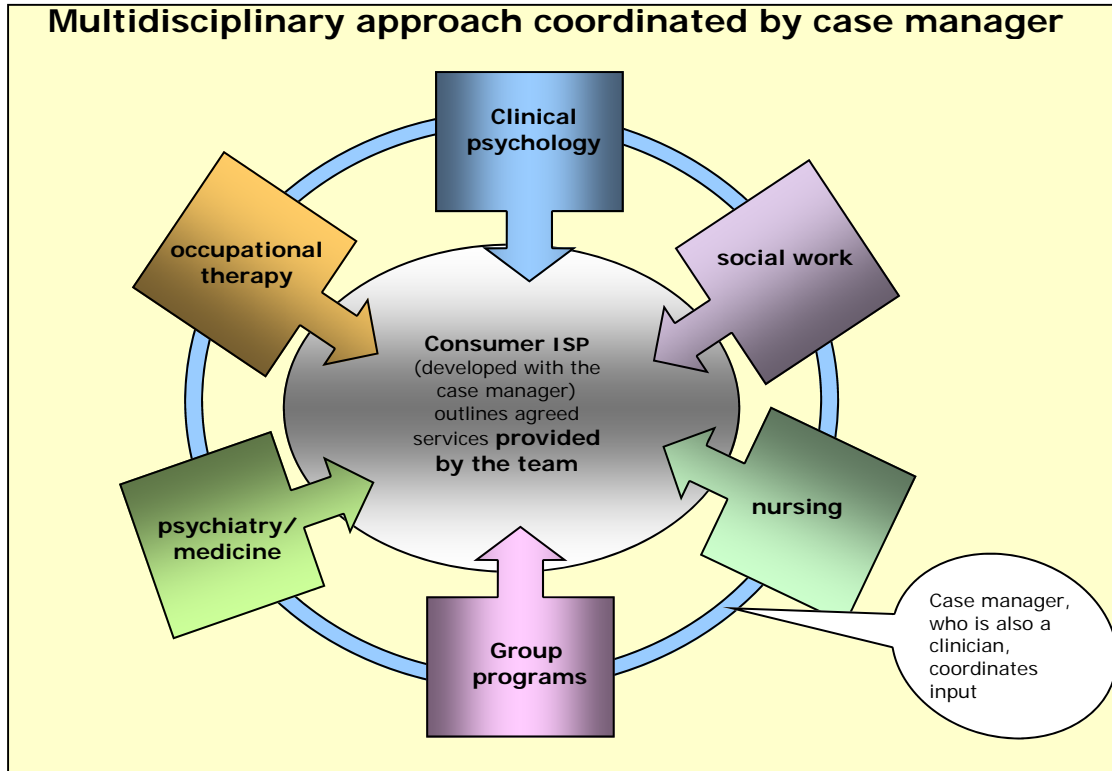
- ❑ Family consultation and support
- ❑ Social network development for consumers and significant others
- ❑ Collaboration with psychiatrists, GPs and other external services and agencies
- ❑ Flexibility to meet individual recovery pathways
- ❑ Advocacy for the consumer and the consumer group

### Who provides *assertive case management*?

The *assertive case management* is provided by all clinicians working within a community multidisciplinary team (MDT), across all service groups, Older Persons, Adult and Child and Adolescent Services. Each clinician will be allocated a case load for which they will be providing *assertive case management*. The case manager will be assisting each consumer to achieve mutually agreed goals from an ISP which they have developed collaboratively with the consumer, carers and others involved in their care. The case manager will provide a clinical service to consumers based on their discipline specific skills, providing evidence based treatment and interventions.

To ensure a multidisciplinary approach to care the case manager will consult with other team members regarding the ISP and where required coordinate clinical input from other clinicians within the team. It is also the case manager's role to liaise with and coordinate input from external service providers and support services, e.g. GPs and Non Government Organisations (NGOs) such as supported accommodation providers.

Wherever possible consumers should be allocated to a clinician with the best skill set to meet the consumer's needs.



Adapted from 'Case Management' by Dowling, R., Fossey, E., Meadows, G and Purtell, C., from *Mental Health in Australia: Collaborative Community Practice*, Chapter 13, Eds: Meadows, G., & Singh, page 210.

## **Integrated Service Model**

*Assertive case management* is one component of the integrated service model. Clinicians will have other roles and responsibilities within the multidisciplinary team. Clinicians will deliver specific treatments, therapies and programs to the consumers serviced by the team according to their specialisation and skills, through a range of activities, as follows:

- Triage (in collaboration with the Mental Health Helpline), Intake and Assessment
- Crisis response and after hours service
- Early intervention
- Specific group programs
- Rehabilitation programs
- Health Promotion/Community Education
- Community development
- Consumer, carer and family participation
- Function as an Authorised Officer (AO), *Tasmanian Mental Health Act 1996*

## **Community Mental Health Services - primary aims of *assertive case management***

- To promote optimal quality of life for people with psychiatric disorders
- To ensure consumers receive comprehensive, coordinated and individualised care, wherever possible within their own community, which is recovery oriented and consumer focused.
- To promote collaboration between the consumer, their family and other organisations involved in delivering care.

## **Functions of the Case Manager**

The role and function of the Case Manager is complex and requires flexibility and judgment in determining the most appropriate service response to the consumer's needs and should include the following<sup>13</sup>:

- ❑ Establishing a collaborative relationship with consumers
- ❑ Ongoing clinical and psychosocial assessments from point of referral to discharge
- ❑ Diagnosis, clinical goal planning, and therapeutic intervention
- ❑ Mental state monitoring and symptoms management
- ❑ Consumer, carer and family: counseling, psycho-education and advocacy
- ❑ Crisis assessment and intervention
- ❑ Clinical review participation

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<sup>13</sup> *Improved access through coordinated care*, Psychiatric Services Branch, Victorian Mental Health Services, Melbourne, 1996, p 17.

- ❑ Community resource brokerage to tertiary health services and/or other community and support services
- ❑ Adherence to best practice guidelines and evidence-based practice without excluding the appropriate use of innovative practice in service delivery
- ❑ File maintenance, documentation and departmental record keeping
- ❑ Outcome monitoring and recording
- ❑ Teamwork and collaboration

It is not a core function of case management to provide non-clinical support for consumers, but rather for CMHS to support carers, families, NGOs and mainstream services in partnership with the consumer to ensure all their needs are met. In fact it is common for consumers receiving clinical support from Mental Health Services to also be receiving support from other agencies, e.g. day support programs such as package of care, and supported accommodation.<sup>14</sup> It is the role of the case manager to have a sound knowledge of services and supports available, liaise and coordinate access to these services, and then monitor and review outcomes.

Case management should be consistently applied in line with the Case Management Society of Australia's 'National Standards of Practice for Case Management'.<sup>15</sup>

As part of a multidisciplinary team, case managers also have additional responsibilities such as:

- Ongoing professional development
- Supervision of students
- Voluntary participation in an On Call Roster
- Adherence to service policies and procedures and all relevant codes of conduct and standards of practice

Case management is a clinical service, which draws on the case manager's skills in engagement with a consumer in responding to his/her needs. The case manager is responsible for coordinating the care delivered to a consumer and will:<sup>16</sup>

- Establish a collaborative relationship with designated consumers
- Ensure that consumers who have urgent needs or require immediate treatment or action, are attended to
- Ensure that the consumer receives a comprehensive assessment through the coordination of psychiatric and needs for service assessments and where necessary, more specialized needs assessment
- Develop an ISP based on the assessment of the consumer needs, which contains clearly specified goals, strategies and responsibilities for action, and
- Ensure the ISPs implementation, monitoring and review
- Ensure relapse and discharge plans are included in the ISP
- Provide direct clinical services where appropriate, including individual, group and/or family treatment

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<sup>14</sup> *Ibid.*, p 18

<sup>15</sup> [www.cmsa.org.au](http://www.cmsa.org.au) 'The Case Management Society of Australia', *National Standards of Practice for Case Management*, Melbourne 2004

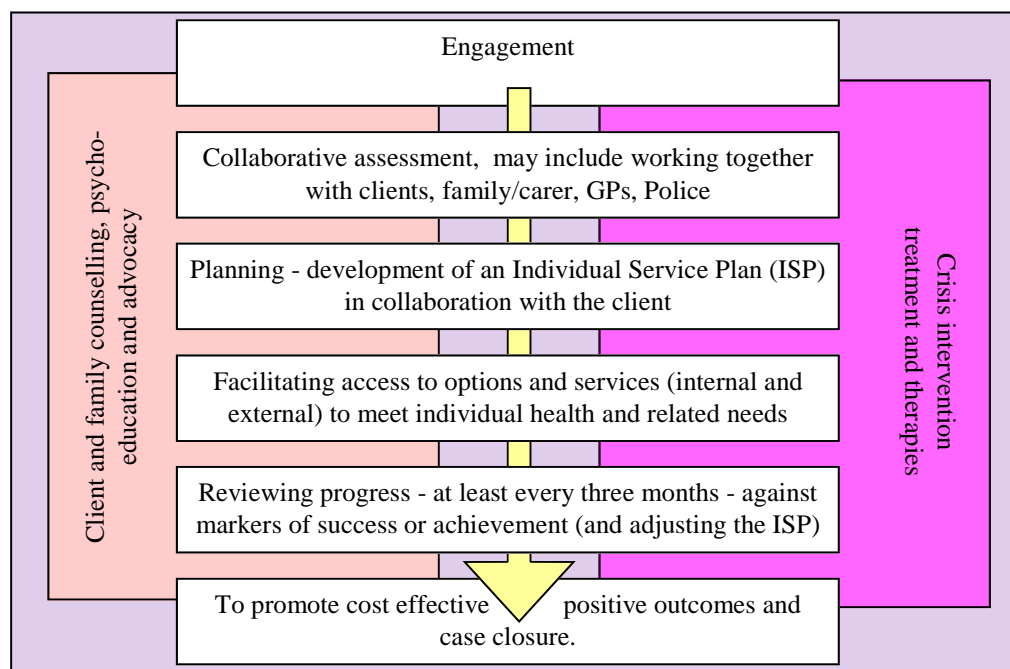
<sup>16</sup> *Ibid.*, p 17

- Monitor periods of consumer care and ensure appropriate discharge/transfer of care to community services
- Facilitate access to services relevant to the consumer needs
- Liaise with and provide feedback to health professionals and others involved in care, including carers, who are involved with the consumer. This must be in line with the requirements of confidentiality
- Ensure that when appropriate, referrals are made to protective services and the police
- Ensure appropriate follow-up after the referral of a consumer
- Ensure case closure where appropriate

For case managers to achieve the above they will need to have an understanding of the aims and practice of *assertive case management*, be able to work collaboratively with consumers, carers and other professionals, and have sound communication and negotiation skills. The case manager will need an understanding the Mental Health Services network and how to work within it for the benefit of consumers together with an ability to establish a supportive relationship with the consumer. In addition case managers need to have:<sup>17</sup>

- Appropriate clinical training as defined by the standards of their respective professional group
- Appropriate training in respect of the Mental Health Act 1996, duty of care, consent and confidentiality
- An ability to assess the urgency of situations and to initiate appropriate action
- An ability to appreciate when referrals to agencies such as police and protective services are appropriate

### Basic Elements of case management



<sup>17</sup> *Ibid.*, p 19

The basic elements of case management will be expanded upon in the section 3 – Individual Service Plans (ISP).

## **Clinical Governance**

### **Responsibilities and Accountability of the Case Manager in the Multidisciplinary Team**

The case manager, as well as providing services directly to an individual consumer is responsible for coordinating other services delivered to each consumer. Each clinician in the team will be individually responsible for their own work in relation to the consumers they provide care to. Each clinician will be responsible for communication with other case managers and team members about the consumers changing needs or any other relevant information. The case manager will be responsible for making sure the consumer has access to the range of Mental Health Services required and negotiating for other services needed. This may include referral to other clinicians within the team for specific therapies or interventions. When this occurs the case manager retains responsibility for coordinating care whilst different clinicians in the multidisciplinary team may have varying degrees of responsibilities for particular aspects of consumer care.

Responsibility for the consumer's treatment while an inpatient, or when on a Community Treatment Order, rest with the treating psychiatrist. A psychiatrist must also be available to provide expert consultation on the care or diagnosis and treatment of community consumers subject to a Community Treatment Order whose case managers are not the treating psychiatrist. In some situations, a private psychiatrist may also provide consultation.

### **Responsibilities of the Multidisciplinary Team**

The multidisciplinary team is required to meet and review cases regularly to ensure a multidisciplinary team approach is applied in determining clinical services for consumers. The team leader is responsible for case allocation to meet both consumer and service needs in a timely and effective manner, ensuring case loads are monitored and individual cases are reviewed at regular intervals and in consultation with the multidisciplinary team determine clinical priority and response to individual consumers.

The team leader must ensure each clinician is provided with supervision and support from both within the team and from each discipline specific stream.

### **Responsibilities of Mental Health Services**

The Chief Psychiatrist and Regional Directors have overall responsibilities for the clinical standard of *assertive case management* at the broader level including:

- the comprehensiveness of assessment and appropriateness of ISPs
- Ensuring staff appointed as case managers have the prerequisite skills to undertake this role, and act in accordance with the Mental Health Act 1996.

Implementation will be delegated to a Senior Consultant Psychiatrist or other senior clinicians of the mental health service providing case management.

The case manager is responsible to their individual Team Leader for undertaking case management and for the standards of case management at the service level.

## **Who Receives Case Management – Intensity and Duration**

The Community Mental Health Service delivers services for two groups of people:

- Consumers with time limited disorders that can be referred back to primary health care providers after a period of weeks or months (an average of 5-6 contacts) when their condition has improved
- Consumers who require ongoing treatment, care and monitoring for more significant periods of time. These will include individuals needing ongoing specialist mental health care for:
  - Severe and persistent mental disorders associated with significant disability, predominately psychoses such as schizophrenia and bipolar disorder.
  - High prevalence disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow-up.
  - Any disorder where there is significant risk of self harm or harm to others arising from mental illness, or where the level of support exceeds that which a primary care team could offer (e.g. chronic anorexia nervosa)
  - Disorders requiring skilled interventions or intensive treatment (e.g. cognitive behavior therapy, psychosocial rehabilitation, medication maintenance requiring monitoring)
  - Complex problems of management and engagement such as those presented by consumers requiring interventions and monitoring under the Mental Health Act 1996.
  - Severe disorders of personality where these can be shown to benefit by continued contact and support.

Consumers described in the second group requiring long-term support for serious and enduring mental disorders are a priority for the CMHS.

An initial assessment (triage) via the Mental Health Helpline of an individual's needs may indicate that another agency may be more appropriate and a referral should be initiated at this point.

Where referrals are received for individuals who have a primary diagnosis and service requirements related to alcohol and drug dependence or intellectual disability it is important that existing protocols, where they exist, are followed or service partnerships are developed.<sup>18</sup> Blueprints for Older Persons and Child and Adolescent Mental Health Services in Tasmania have identified in detail their own service target groups and these are included in the attachments to this resource.

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<sup>18</sup> 'Adult Community Mental Health Blueprint', *Mental Health Services*, Department of Health & Human Services, Hobart, 2006, p 5.

The emphasis under the National Mental Health Plan 2003-2008 is to maintain consumers in their own environments rather than promoting their move to major population bases. There has also been a progressive shift of consumers with Serious Mental Illness (SMI) to NGOs for long-term disability support.

CMHS, using a multidisciplinary approach, will provide adequate outreach, through case management to:

- Increase capacity within the primary care sector through collaboration.
- Reduce the stigma associated with mental health care.
- Ensure that care is delivered in the least restrictive and disruptive manner possible.
- Stabilise social functioning and protect community tenure.

Additionally, CMHSs must be able to support consumer recovery by:

- Providing prompt and expert assessment and treatment of serious mental health problems and illnesses to consumers in their own community.
- Providing effective, evidence-based treatments to reduce and shorten distress and suffering.  
'Recovery happens when Mental Health Services are staffed by people who are compassionate and competent in giving people the best help available.'<sup>19</sup>
- Contributing to an integrated service response within the area of mental health services through effective linking with other service components,  
'Recovery happens when Mental Health Services enable people to find the right help at the right time, regardless of who they are and where they are. Monitoring and coordinating the provision of services to consumers to ensure continuity of care in the least restrictive environment.'<sup>20</sup>
- Ensuring that inappropriate or unnecessary treatments are avoided.  
'Recovery happens when Mental Health Services can assist people not to use services unnecessarily or stay in them for too long.'<sup>21</sup>
- Establishing effective liaison with local Primary Care Team members and other referring agents to shape referrals and support local care and have a detailed understanding of all local resources relevant to the support of individuals with mental health problems.  
'Recovery happens when Mental Health Services can look outward and assist people to find and use other community services, supports, and resources.'<sup>22</sup>
- Involving the consumer's family/carer as an equal partner in the consumer's treatment and to maximize the use of community supports available within the consumer's usual environment.
- Treating consumers as equal partners in the delivery, planning and development of community Mental Health Services.

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<sup>19</sup> 'Blueprint for Mental Health Services in New Zealand: How things need to be', New Zealand Mental Health Service Commission, Wellington, 1998, p. 17

<sup>20</sup> *Ibid.*, p. 17

<sup>21</sup> *Ibid.*, p. 18

<sup>22</sup> *Ibid.*, p. 18

- Providing advice and support to service users, families and carer's.
  - 'Recovery happens when Mental Health Services provide for people in the context of their whole lives, not just their illnesses'<sup>23</sup>
- Providing a culturally competent and sensitive service for minority groups and consumers with physical disabilities.

## Case Load

Caseload sizes and team configurations should be calculated on the given population of an area that the team is responsible for. Case loads will vary according to

- Complexity of need
- Local demographics (e.g. rural or metropolitan responsibility)
- Existence of other Mental Health Services

Case loads are based upon an expectation that a CMHT member spends 80% of his/her time in direct consumer related activities and 20% of his/her time in professional and personal development activities (e.g. teaching, peer reviews, research, case reviews, supervision, team meetings) In addition case managers have other responsibilities to the MDT, such as crisis response and intake duties, regional group programs and early intervention activities. MHS (West, 2006) have developed a discussion paper on the determination of case load allocation<sup>24</sup>, (included in attachments) It includes a 'Case Load Allocation' tool, which was trialed for a 6 month period across the MHS community sector during 2006..

It is recognised that different team structures agreed locally will require different staffing structures and there must be a degree of flexibility.

## Importance of discharge planning in case load management

The process for discharge planning commences at admission where goals for care and discharge are determined. Intake and assessment processes must establish what the needs of the consumer are that require specialist mental health intervention, and to what degree these need to be met before the consumer can be discharged. Promoting discharge at intake demonstrates a commitment to a recovery model of service and empowers the consumer to take steps towards recovery based on their goals, using their strengths and community resources available to them.

'Unless discharge options are actively pursued, where appropriate, there is a risk case loads will be excessive. Active case management, regular clinical reviews and case load monitoring requires input from all levels of the multidisciplinary team, from the individual clinician to the team leader and the consultant psychiatrist, to consider the required level of service, who should provide that service and alternative service providers.'<sup>25</sup>

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<sup>23</sup> *Ibid*, p. 18

<sup>24</sup> West K, *Case load Allocation Discussion Paper*, Mental Health Services, DHHS Tasmania 2006 unpublished

<sup>25</sup> 'Aged and Community Health Division, Mental Health Chief Psychiatrist Guideline', *Discharge Planning for Adult Community Mental Health Services*, Melbourne, 2002, p 2.



## Section 2

### Integrated Care Pathway

Section 2 of the manual steps through the care pathway giving specific details of how the model is applied within an integrated multidisciplinary team setting.

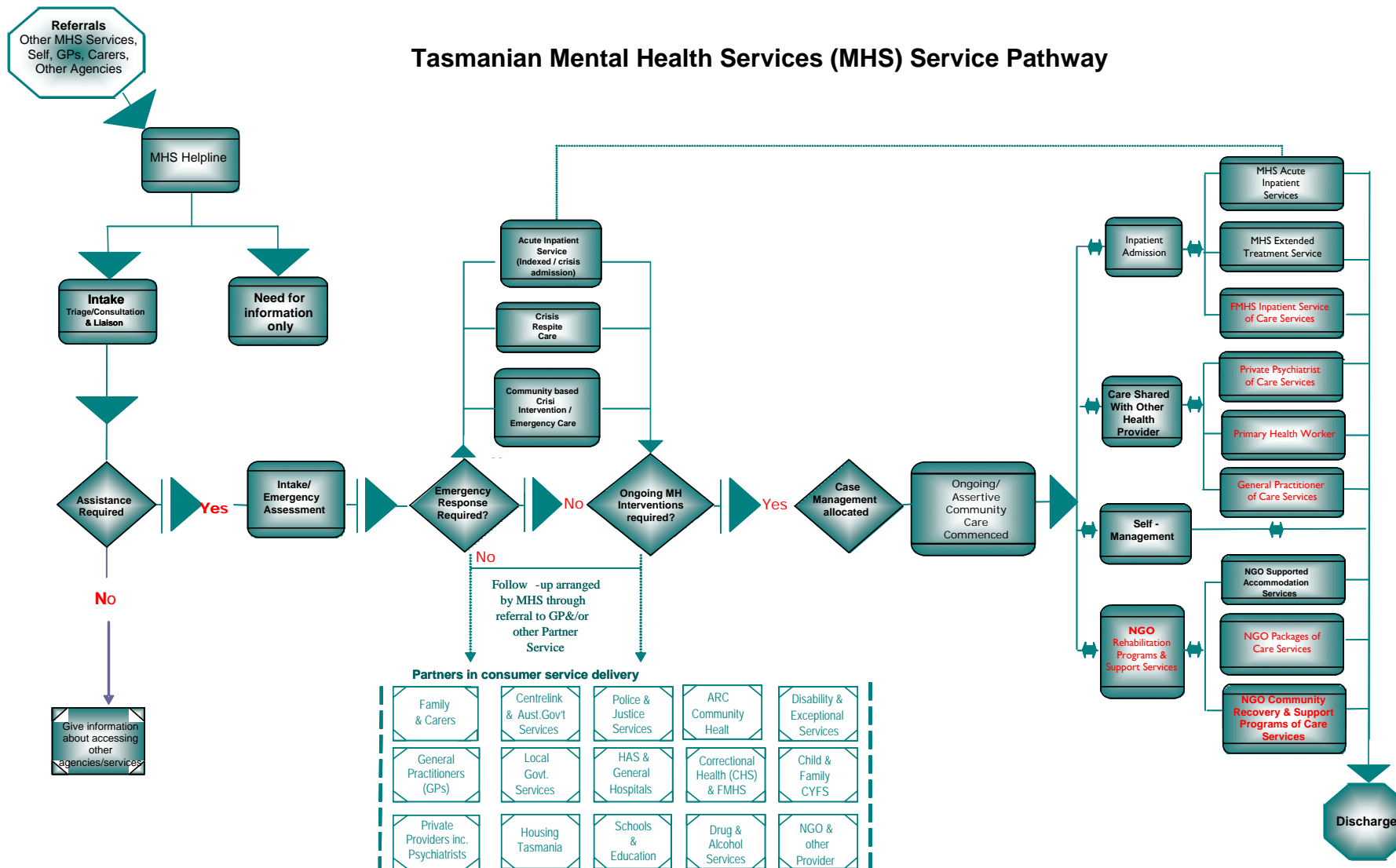
*Assertive case management* has been described as both a ‘cornerstone of community treatment’<sup>26</sup> and the ‘most effective tool for optimal continuity of care for consumers within a mental health service’<sup>27</sup>. It provides the framework for care of all consumers entering our service, but needs to be understood in context of the multidisciplinary team, integrated service model adopted by CMHS.

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<sup>26</sup> Kanter J.M.S.W, *Clinical Case Management: Definition, Principles, Components*, Hospital and Community Psychiatry April 1089 Vol. 40 No. 4 p 361

<sup>27</sup> *Ibid.*, p 361

# Tasmanian Mental Health Services (MHS) Service Pathway



## Case management and the care pathway

Case management functions are distinct from triage, intake, consultation and liaison, as well as specific prevention, promotion and early intervention activities; as these are usually time-limited in nature.

The major steps of the care pathway for the provision of service to consumers referred by the Mental Health Helpline or an acute inpatient unit for case management and ongoing clinical services are summarized as follows:

- **Intake and Assessment**

Each CMHT will provide its own intake, assessment and referral where possible. Assessment for a consumer will be conducted by the clinician most likely to provide ongoing case management. Assessments are then discussed by the multidisciplinary team and if required formal allocation of a case manager is progressed. Alternatively referral to early intervention programs or alternative services can be determined by the team.

- **Case Coordination and Care Planning**

On acceptance and service entry, the consumer will be allocated a case manager. The case manager works as part of the multidisciplinary team to undertake formal assessments to develop an ISP and Recovery Plan for consumers requiring both short term and long term care.

The ISP will specify the level of service to be provided to the consumer and significant others by the CMHS. The case manager will coordinate access to specialist treatments, groups and support services and ensure continuity of care if a consumer is admitted to inpatient service within MHS.

- **Review and Discharge Planning**

The ISP/recovery plan is reviewed quarterly with the consumer, the multidisciplinary team and others service providers involved in the consumers care. Discharge occurs when the ISP goals have been met, and or the consumer no longer requires specialist Mental Health Services.

- **Discharge / Transfer of care**

Arrangements are documented with comprehensive discharge information indicating current treatment, existing supports and relapse prevention plans being provided to primary health providers and support services on transfer of care. Formal transfer of care occurs at the time of active engagement by the primary healthservices/supportservice.<sup>28</sup>

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<sup>28</sup> 'A proactive and collaborative model', *Adult Community Mental Health Service Assertive Case Management*, Mental Health Services, Hobart, 2005, p. 7

The following table describes in detail key elements of care and the components of each, to give clinicians a clear expectation of the application of an *assertive case management*; a proactive approach model, from within integrated services provided by multidisciplinary community teams. These reflect evidence based practice, professional standards, National Mental Health Standards and the National Mental Health Plan. They also incorporate the principles outlined in the Tasmanian Mental Health Services Strategic Plan. This table draws upon the United Kingdom NHS Mental Health Policy Implementation Guide, Community Mental Health Teams 2001<sup>29</sup>

**Table 1: Key Components of Care by Community Mental Health Service**

Key Component	Elements	Comments
<b>Working with Primary Care</b>	<ul style="list-style-type: none"> <li>• Pre-referral discussion through regular attendance of key worker at primary health care, GP or NGO service provider's sites.</li> <li>• All referrals should be a single point of entry via triage (the Mental Health Helpline).</li> <li>• Even if referrals are targeted to an individual team member they should go through the same process to ensure appropriate and consistent management.</li> </ul>	<ul style="list-style-type: none"> <li>• Helps to ensure appropriateness of referrals and supports GPs and NGOs in identifying possible alternatives.</li> <li>• This enables a much more informed post-triage team discussion and allocation.</li> </ul>
<b>Assessment</b>	<ul style="list-style-type: none"> <li>• Everyone who is referred should be triaged via the Mental Health Helpline.</li> <li>• Same day crisis response and emergency assessment (within each Regional Area) should be available via the team if indicated by the Mental Health Helpline triage process.</li> <li>• Large teams will form clusters to clinically manage groups of clients.</li> </ul>	<ul style="list-style-type: none"> <li>• Not possible to limit assessments to mentally ill – GP skills vary and advice on the management of common disorders and also confirmation that people are not suffering from a psychiatric disorder is part of the service.</li> <li>• Teams need to establish local arrangements for crisis resolution teams</li> <li>• Bench mark need to be established based on fully</li> </ul>

<sup>29</sup>NHS *Mental Health Implementation Guide, Community Mental Health Teams*, London, United Kingdom, 2001, pp. 7-17.

	<ul style="list-style-type: none"> <li>• Routine intakes should be prompt.</li> <li>• Most assessments of those with severe mental illness should involve trained medical staff where ever possible.</li> <li>• Assessments should be undertaken by clinical staff skilled in assessment and crisis response.</li> <li>• Mental Health examinations and additional assessments should be conducted by appropriate members of the CMHT during working hours using an agreed format and standardised suite of tools.</li> <li>• The outcome of the assessment should be communicated to the consumer and referrer promptly.</li> <li>• The consumer should be involved in the assessment so that by the end they already have an understanding of the situation.</li> </ul>	<p>resourced community services post 'Bridging the Gap' funding</p> <ul style="list-style-type: none"> <li>• Whenever possible, people should have a choice about where they are seen, e.g. at GP surgery, at home.</li> <li>• Letters should be sent within a week to consumer and GP or primary service provider</li> </ul>
<p><b>Team Approach</b></p>	<ul style="list-style-type: none"> <li>• Crisis Response staff will provide handover to the multidisciplinary team on a daily basis.</li> <li>• Once accepted for treatment each consumer will be assigned to a case manager who has overall responsibility for ensuring appropriate assessment, care and review</li> <li>• Assessments and reviews to be routinely discussed by the clusters/whole team in a time-tabled weekly meeting.</li> <li>• All after hours and crisis contacts are discussed with the clusters/whole team and or the case manager on a daily basis</li> <li>• Case loads managed within the clusters/whole team to ensure effective use of resources.</li> <li>• Cross cover is within the clusters/whole</li> </ul>	<ul style="list-style-type: none"> <li>• Ensures the Team have input and are aware of issues arising, i.e. priority needs for the service</li> <li>• Case Management should be consistently applied in line with the Case Management Society of Australia's National Standards of Practice for Case Management.</li> <li>• Single point accountability.</li> <li>• Allows for appropriate allocation of case manager reflecting skills and training. Does not rely on individual members to flag up problems, enables provides peer review and support.</li> <li>• Ensures timely and accurate handover of information.</li> <li>• Case load to be determined using case load tool adopted by MHS</li> <li>• Spreads and exploits common knowledge about users. Improves peer review.</li> <li>• Ensures less experienced staff, i.e. new staff or students</li> </ul>

	<p>team rather than necessarily being profession specific. Continuity of care is provided by the team.</p> <ul style="list-style-type: none"> <li>• Level 1 staff (e.g. Occupational Therapy, Psychology, Nursing and Social Work) must be supervised by experienced clinicians.</li> <li>• Clear clinical and managerial leadership should be established which crosses all the disciplines.</li> </ul>	<p>who have a significant contribution to make to a team, are adequately supported and supervised in delivery of care.</p> <ul style="list-style-type: none"> <li>• The responsibility for standards of care is a joint one between the resident consultant psychiatrist and team leader. Other areas involved in the human resource and cost centre resource management of the team are the responsibility of the Team Leader. In recognition of the increasing workload arising from devolved responsibility for these tasks, Team Leaders should not undertake active consumer caseloads.</li> </ul>
<b>Regular Review</b>	<ul style="list-style-type: none"> <li>• Minimum of 2 weekly clusters/whole team meetings should include the consultant psychiatrist where actions are agreed and changes in treatment discussed by the cluster.</li> <li>• Progress and outcomes regularly monitored.</li> <li>• ISPs should be formally reviewed and updated at a frequency determined by need. This must remain an ongoing process, which can be initiated by any member of the care team or the consumer or carer.</li> <li>• Regular reviews must also be conducted with a primary health carer, GP or NGO providers (in their work setting).</li> </ul>	<ul style="list-style-type: none"> <li>• This should include consumers and carers where possible.</li> <li>• Appropriate structured assessments should be used to monitor progress, utilizing the standard documentation suit</li> <li>• Risk assessment should be a routine, recorded component.</li> <li>• Regular reviews are a requirement of the National Mental Health Standards.</li> <li>• This is a vital and effective way of both supporting providers and ensuring that effective communication occurs between primary and secondary care. MHS needs to be responsive to other providers.</li> </ul>
<b>Documentation</b>	<ul style="list-style-type: none"> <li>• Records should be kept of all contacts with the consumer and with significant others in relation to the care that the consumer received.</li> <li>• An assessment of the current mental status of consumers following all contacts must be recorded as well as an assessment of current level of risk.</li> </ul>	<ul style="list-style-type: none"> <li>• It is also useful to have protocols for the exchange of relevant information between agencies and a transparent consumer consent process.</li> <li>• Document suite ensures continuity of care.</li> <li>• Consumer files must conform to required standards. Additionally, nurses must adhere to the NBT documentation standards and all MHS employees must adhere to relevant policies.</li> </ul>

	<ul style="list-style-type: none"> <li>• There should be a single file for each consumer case treated by CMHS.</li> <li>• Consumer records must be maintained in a confidential and secure manner.</li> <li>• All written entries by MHS staff in consumer files must conform to policy requirements, e.g. date, time, legible, author identified by designation and written name etc.</li> <li>• Electronic records, where developed, and must conform with the MHS minimum data set.</li> </ul>	<ul style="list-style-type: none"> <li>• MHCHIPS Clinical Reference Group are working to ensure MHS needs addressed in CCHP.</li> </ul>
	<p><b>INTERVENTIONS : (primarily, but not exclusively, for those with short-term needs)</b></p>	
<p><b>Psychosocial Interventions</b></p>	<ul style="list-style-type: none"> <li>• Psychological approaches/therapies should be routinely considered as an option when assessing mental health problems.</li> <li>• A range of techniques both for reducing the severity of symptoms and for increasing resilience to cope with the illness should be made available to all who might benefit from them. These include CBT, stress management, brief counseling.</li> <li>• Provision of psychological therapies in CMHT will be determined by: <ul style="list-style-type: none"> <li>- Consumer needs.</li> <li>- Staff training and expertise.</li> <li>- Resources available</li> </ul> </li> <li>• All staff should have the following skills: <ul style="list-style-type: none"> <li>- Counselling skills (including the ability to establish, maintain and terminate therapeutic relationships and active listening and effective communication skills).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Psychological approaches/therapies are fundamental to basic mental health care and have an important place amongst the range of treatments available as part of a comprehensive, consumer-centered mental health service.</li> <li>• As the evidence base for their effectiveness has grown so has the expectation of choice and availability by consumers and carers.</li> <li>• This provision of psychological support / therapies is not restricted to clinical psychologists. Postgraduate training is available in many of these techniques and staff must be encouraged and supported to obtain these skills.</li> <li>• Careful consideration of capacity and the use of the guidelines are essential to avoid inappropriate referral, delay, multiple assessments and false starts.</li> <li>• Clinical Reference Groups for each sector will be involved in recommending a list of approved psychotherapeutic, evidence based interventions for</li> </ul>

	<ul style="list-style-type: none"> <li>- Assertiveness training</li> <li>- Supportive counselling for families and carers.</li> <li>- Problem solving, goal setting and motivational interviewing.</li> <li>- Encouraging adherence to treatment skills (concordance skills)</li> <li>- Grief and loss counselling.</li> <li>- Cognitive Behavior Therapy.</li> <li>- Psycho education for use in both individual and group work.</li> </ul> <ul style="list-style-type: none"> <li>• Consumers should have clear guidelines as to the range of therapies on offer by the CMHT and the most effective form of treatment for their condition.</li> <li>• The provision of psychological therapies must be identified and monitored with an agreed process for adding therapies to the scope of work of the CMHT on a statewide basis.</li> </ul>	CMHS (Adult, Child & Adolescents and Older Persons).
	<b>INTERVENTIONS: (primarily, but not exclusively, for those requiring longer term case management).</b>	
<b>Physical Health Care</b>	<ul style="list-style-type: none"> <li>• Every consumer in the care of the CMHT should be registered with a GP.</li> <li>• Consumers should be actively encouraged and supported in accessing primary health care and health improvement.</li> <li>• Physical health problems should be identified and discussed with GP. Where consumers will not attend their GP the team must take responsibility for activities to promote general health and well being of consumers.</li> <li>• Management plans for consumers with SMI</li> </ul>	<ul style="list-style-type: none"> <li>• Though not always possible, strenuous effort should be made to achieve this.</li> <li>• This may sometimes involve providing help in keeping appointments etc. Severe mental illness is associated with significantly poorer physical health status and a current life expectancy of 53 years of age.</li> <li>• Mortality in people with SMI is greater from physical ill health than from suicide – therefore managing the physical health problems should remain a priority – and be a further reason to link effectively with the primary healthcare provider.</li> </ul>



	<p>must include strategies to promote physical well-being.</p>	
<b>Continuity of Care</b>	<ul style="list-style-type: none"> <li>• The case manager is responsible for ensuring continuity of care using home visits, repeat appointments etc.</li> <li>• Clear instructions must be provided to the consumer for contact out of hours and who to contact when the case manager is away.</li> <li>• Contact frequency will vary over time according to consumer need.</li> <li>• As much as possible contact with the consumer should be maintained by the case manager when the consumer is admitted to inpatient care .</li> <li>• Contact and communication should be maintained with the GP or primary health care provider so he/she is informed of significant changes in the consumer’s mental health, medication, etc, whilst in the care of the CMHT.</li> <li>• Wherever possible transfer of clients between case managers should be minimized to ensure continuity of care</li> <li>• All consumers and their families should have provided, as a minimum, the following information on the services both in printed form and as part of individual engagement. <ul style="list-style-type: none"> <li>- Description of the service, the range of interventions provided and what to expect.</li> <li>- Name and contact number of the case manager.</li> <li>- Management plan including relapse</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Clear written instructions on how to contact CMHT members responsible for aspects of the care are to be made available to all involved.</li> <li>• This will include details about contact after hours and/ or alternative emergency contacts.</li> <li>• Capacity to increase visits during initial engagement and crises needs to be build into case manager’s schedules, and will affect case loading.</li> <li>• Standards for ‘in-reach’ may need to be formalised between consumer services and CMHT.</li> </ul>

	<p>and crisis plan.</p> <ul style="list-style-type: none"> <li>- Contact details for out of hours advice and help.</li> <li>- Contact number of MH Helpline</li> <li>- Specific information in relation to prescribed psychotropic medications.</li> <li>- Information on how to express their views and make complaints.</li> <li>- Information on relevant forums, support groups and alternative providers.</li> </ul>	
<b>Medication</b>	<ul style="list-style-type: none"> <li>• The team should be responsible for monitoring medication as indicated by clinical need, with blood tests as necessary to monitor therapeutic levels or side effects.</li> <li>• Close and effective links needed with GPs where they prescribe or administer.</li> <li>• Depot antipsychotic administration should be available at the consumer's home or agreed place (when safe to do so).</li> <li>• Strategies to improve compliance with the medication regime must be in place.</li> <li>• Structured side-effect monitoring should be routinely undertaken and be included in ISP documentation.</li> </ul>	<ul style="list-style-type: none"> <li>• Regular supervision and monitoring of oral medicines should be available for consumers subject to compulsion under the MHA who have a history of non-compliance.</li> <li>• Ensures continuity of care</li> </ul>
<b>Activities of Daily Living</b>	<ul style="list-style-type: none"> <li>• For those with severe and enduring mental illness, the management plan must include areas of particular vulnerability / risk and identify strategies to address these.</li> <li>• Direct practical help should be co-ordinated by the CMHT case manager for a range of basic needs such as obtaining centre link benefits, budgeting, shopping, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Assertive advocacy with other agencies, e.g. landlords, employers on behalf of the consumer is part of a case manager's responsibility.</li> <li>• This may include accessing support services such as Packages of Care, and Supported Accommodation</li> <li>• Different consumers will benefit from direct support or training in these activities.</li> <li>• Team members should be able to <b>assess</b> when it is</li> </ul>

	<ul style="list-style-type: none"> <li>• This will usually involve identification of a mental health support worker / NGO provider. E.g. packages of care</li> </ul>	<p>better to <b>'do for'</b>, <b>'do with'</b> or <b>teach a skill</b>.</p> <ul style="list-style-type: none"> <li>• Respect for consumer's independence needs to be balanced against risk of demoralisation from repeated failure.</li> </ul>
<b>Recovery-orientation</b>	<ul style="list-style-type: none"> <li>• Ensuring consumers are encouraged and assisted to obtain / maintain employment where possible.</li> <li>• The team should compile and maintain a resource file of local service provision and opportunities.</li> <li>• Case managers must assist consumers to participate in/access self-help and peer-run services.</li> <li>• Consumers, with the support of case managers should develop a recovery or wellness recovery action plan as part of ISP.</li> <li>• Adequate time must be allocated to provide emotional support to consumers and carers.</li> <li>• Consumers should have access to a range of therapeutic programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Case managers should co-ordinate the provision of practical help such as filling in application forms, accompanying consumers to interviews, etc.</li> <li>• Educational opportunities can both provide useful extra skills and structure the day.</li> <li>• Living with a severe mental illness can be demanding and demoralising. Without attention to emotional support, consumer collaboration in specific treatments is likely to be compromised.</li> <li>• This plan focuses on wellness including the treatments, supports and resources that will facilitate the consumer's recovery.</li> <li>• Involvement of the consumer's family, partner and friends may enhance the recovery process. The consumer should define whom they wish involved.</li> <li>• Fostering collaboration between consumers and carers can ameliorate the need for more restrictive treatment approaches for the consumer.</li> </ul>
<b>Family / Carer Support</b>	<ul style="list-style-type: none"> <li>• Carers should have their needs reviewed formally on at least an annual basis.</li> <li>• Families and carers to be involved in the consumer's care and management planning as much as possible (with consent).</li> <li>• Education and information about the consumer's illness and treatment need to be provided and repeated.</li> <li>• Family therapy – where indicated, should be available for families.</li> <li>• Assessment must be completed on a routine</li> </ul>	<ul style="list-style-type: none"> <li>• This is independent of the consumer's wishes. Practical help should be available, e.g. respite.</li> <li>• Not all consumers will accept involvement of their families.</li> </ul>
<b>Family / Carer Support (cont'd)</b>		<ul style="list-style-type: none"> <li>• CMHT staff are generally not trained in assessing</li> </ul>

	<p>basis of the overall well being of dependent children whose needs may be compromised by parental illness. Involvement of the appropriate children and families team if indicated.</p> <ul style="list-style-type: none"> <li>• Where dependent children act as carers their own needs require regular and careful attention.</li> </ul>	<p>parenting ability but can recognise when a consumer's illness or problems pose a significant burden or risk for family members and, if concerned, discuss it with the consumer. The child's needs must take priority.</p>
<b>Relapse Prevention</b>	<ul style="list-style-type: none"> <li>• Individualised relapse plans should be agreed with all involved, i.e. case manager, consumer services, GP, carer, etc. and kept on file as part of ISP.</li> <li>• Case managers must assess and document stressors which precipitate consumer relapses.</li> </ul>	<ul style="list-style-type: none"> <li>• Some consumers have highly specific "relapse histories/markers" and these should be part of the relapse prevention section of the management plan.</li> <li>• Sharing relapse plans with others involved in care increases the likelihood of timely response.</li> </ul>
<b>Treatment of Substance Abuse</b>	<ul style="list-style-type: none"> <li>• All team members should undertake assessments of alcohol and drug use and its impact on consumer presentation.</li> <li>• The team should be able to offer advice about seeking alternative help or, where this is not accepted or possible, deliver basic harm minimisation interventions and motivational interviewing.</li> </ul>	<ul style="list-style-type: none"> <li>• Alcohol and drug use complicate a significant proportion of presentations to CMHTs.</li> <li>• Links to Alcohol and Drug Services (ADS) need to be clear and well supported.</li> <li>• Where an individual is referred to another team, the GP must be informed (to prevent the individual falling between two services). NB: The consumer remains MHS responsibility until formal handover and active engagement in ADS occurs.</li> <li>• Staff should have access and obtain training in substance abuse management, where required</li> <li>• People with a psychotic illness are best cared for by one team that can provide both inputs rather than divided care.</li> </ul>
	<b>Liaison With Other Parts Of The Health System</b>	
<b>Inpatient Care</b>	<ul style="list-style-type: none"> <li>• Direct admissions should be facilitated for</li> </ul>	<ul style="list-style-type: none"> <li>• Many potential consumer admissions may be avoided</li> </ul>

	<p>current consumers where ever possible.</p> <ul style="list-style-type: none"> <li>• CMHT case managers should as much as possible continue contact with the consumer (see continuity) and be involved with consumer or home treatment team in regular reviews and treatments.</li> </ul>	<p>by the timely provision of home treatment or care in a crisis/respite house.</p> <ul style="list-style-type: none"> <li>• Local consumer units are an essential part of the whole MHS system and admission must not be seen as a CMHT failure.</li> </ul>
<b>Discharge From Hospital</b>	<ul style="list-style-type: none"> <li>• CMHT (and primary health care or NGO providers) should be fully involved in discharge planning/transfer of care to community service.</li> <li>• All consumers should have a first follow-up within a week of discharge from inpatient care.</li> <li>• Regular contact between the CMHT and key providers of services to consumers should take place at agreed intervals.</li> <li>• This should involve discussion of joint consumers and problems.</li> <li>• This can also include those consumers who are managed entirely in the primary care sector and not known to secondary services (up to 30% of people with a serious mental illness).</li> </ul>	<ul style="list-style-type: none"> <li>• Prior to discharge all involved agencies need to be consulted and kept up to date.</li> <li>• Management (including crisis and relapse) plans should be reviewed by case manager prior to consumer discharge.</li> <li>• Review of literature identifies this as the high risk period for occurrence of sentinel events such as suicide and homicide.</li> <li>• Local arrangements to monitor and support this are required.</li> <li>• A time tabled meeting (not around emergencies) means that greater understanding can evolve about mutual strengths and weaknesses.</li> <li>• Liaison strategies may vary depending on locally agreed arrangements.</li> </ul>
	<b>Discharge And Transfer Of Care Arrangements</b>	
<b>Routine Transfer</b>	<ul style="list-style-type: none"> <li>• Transfer of consumers to another CMHT should involve a joint meeting of case managers (old and new).</li> <li>• Cessation of involvement of existing case manager should not occur until the new case</li> </ul>	<ul style="list-style-type: none"> <li>• It is the responsibility of the in-taking team to ensure this process is affected efficiently and in a timely manner.</li> <li>• Clients may be vulnerable of relapse at time of transfer.</li> </ul>

	<p>manager has established rapport with the consumer.</p> <ul style="list-style-type: none"> <li>• Transfer arrangements need to be carefully documented as this involves a transfer of responsibility and duty of care.</li> </ul>	
<b>Emergency Transfer</b>	<ul style="list-style-type: none"> <li>• As a rule, consumers should not be transferred in crisis. Where this is inevitable the case manager must make direct contact with the receiving service to ensure efficient transfer of relevant information.</li> </ul>	
<b>Discharge from CMHT Care</b>	<ul style="list-style-type: none"> <li>• Consumers must be discharged back to primary health care providers when they are recovered. This is essential to protect capacity for intake and new referrals.</li> <li>• Discharge information needs to be comprehensive and indicate current treatment and procedures for re-referral.</li> <li>• Consumers with complex care needs will need discussion at liaison meetings with ongoing providers prior to discharge.</li> <li>• On discharge, all clients should be discharged from the client information system (OARS).</li> </ul>	<ul style="list-style-type: none"> <li>• Discharge information must include risk assessment/management and relapse prevention information for ongoing service providers.</li> </ul>

## Section 3: Individual Care Plans (ISP)

### Developing ISPs

It is National Mental Health Standards requirement that each consumer has an *Individual Service Plan (ISP)*. It is the core role of a case manager to develop the ISP in collaboration with the consumer, the multidisciplinary team, carers and family and other service providers.

ISPs provide a planning tool, designed to ensure services are delivered according to the individual needs of each consumer. When the individual care plan is completed it remains in the case file and is accessible to all clinicians from the multidisciplinary team. The availability of the ISP ensures all mental health staff are able to intervene with the consumer in a consistent manner inline with what has been planned.

#### **An ISP should detail:**

- People involved in the care planning process, e.g. case manager, GP, carer, etc.
- Identify the consumer's strengths
- The current situation and definition of problems
- Identified goals/issues to improve the situation and indicators of their achievement
- The strategies/interventions for achieving goals
- The person/s responsible for implementing strategies
- The date for review.

For many consumers the ISP may be brief and cover a limited number of areas.

For others with more complex needs, the ISP will represent a summary of care being offered with further detailed plans developed and implemented according to the type of treatment or intervention provided. These plans will be much more comprehensive in nature, may cover an extended period of time and will reflect the increase intensity of care provided.

Similarly a consumer whose ISP states CBT for management of depression, may well have some additional assessments completed. These along with specific plans and strategies, progress and reviews are documented in the consumer's clinical record. Outcomes from these specific interventions are then used to inform the outcomes of ISPs at regular review periods.

The Tasmanian Mental Health Service is committed to developing a standardised documentation suite for use across all areas of clinical service, including hospital and community based services. When finalized, this should include mandatory assessment formats, ISPs, and discharge plans which will need to be completed for each consumer entering the service either by admission to hospital or via the Mental Health Helpline and subsequent service intake through community teams. The format for ISP and the standard documentation suite will be consistent with the National Mental Health Standards.

It is important to note here that there will be some variations between the intake assessments, ISP's and discharge plans that are developed for the three consumer groups served by MHS's, Older Persons, Adult and Child and Adolescent services. This variance between each set of documentation ensures that the needs of each of these distinct groups of consumers are addressed through targeted assessments and plans.

From a community perspective regardless of which area of MHS the consumers has contact with, the fundamental process of individual care planning will not change.

The most obvious exception is that with children and adolescence and older persons where their family and carers as legal guardians will be more directly involved in decision making about treatment and care, as either a parent, husband or next of kin.

The following outlines the process of individual care planning, from intake through to discharge, emphasising the case manager's role throughout.

### **OARS data collection**

The Tasmania Mental Health Service currently collects consumer clinical information statistics using the OARS data base. Information is collected on admission, at review and on discharge for every consumer entering the system. In addition, all clinical contacts with consumers are recorded. All clinicians are required to collect this information and record their contact with consumers. It is critical staff comply with this requirement as the data collected forms the basis of mandatory national reporting requirements under the National Outcomes Casemix Collection (NOCC) protocol agreement with States and Territories. The consumer's outcome measures, HoNOS, Basis 32 and Life Skills Profile form the basis of the NOCC protocols to be reported and are required to be undertaken at admission, review (3 monthly) and discharge. An OARS review is also required if there is a change of service, e.g. admission to hospital from the community.

The OARS data collected provide the basis for review of the effectiveness of care at both an individual consumer level and for the services as a whole. Data is also used to inform service planning and resourcing.

Whilst intake staff are responsible for completing initial intake forms, the allocated case manager is responsible for completing the OARS admission data sheet and completing a HoNOS rating for the consumer on admission. In addition the Basis 32 and Life Skills Profile are also completed as a part of the consumer outcome measures collected through OARS. The information gained from these assessments is also considered in planning and prioritizing care for the consumer. Case managers are responsible to ensure OARS Reviews are undertaken 3 monthly and at discharge. Resource manuals for OARS data collection are available for clinicians at all units and centres throughout Mental Health Services.



## **Triage Intake and Assessment**

### **Triage**

Triage will be undertaken by the Mental Health Helpline which operates 24 hours per day 7 per week on a free-call 1800 number. Referrals assessed as requiring further intervention from Mental Health Services are then forwarded to the CMHT who service the area from which the referral has originated. Triage details are entered onto the 'TRIO' data base, accessible to community mental health clinicians via the DHHS intranet

While the Helpline is the preferred point of entry to MHS, and wherever possible all referrals should be directed to the Helpline, there may be occasions when consumers enter MHS via service units. When this occurs, the clinician accepting the referral must complete a triage assessment and enter the details on the 'TRIO' data base.

### **Intake**

Whenever possible, service intake should be undertaken by the clinician who is most likely to continue as the case manager. It is important also to note here that information gained through the intake assessment will form the basis for the consumer's ISP, which in turn, is the basis for implementation of treatment, monitoring and review. It is not necessarily the role of the intake officer to undertake every assessment needed by the consumer, but rather to ensure that a comprehensive assessment is undertaken and that this information is used in a meaningful way. At point of intake all OARS data intake forms are to be completed by the person responsible for intake.

It is essential that a range of appropriate service providers are involved in the intake assessment. This may involve not only the intake officer, but also key workers from other support services, primary health services, GPs, family and carers. It is equally important that the consumer's preferences and choices are respected in relation to who is involved in the intake assessment. Consent for disclosure of information to carers and family members should be sought from the consumer, otherwise disclosure must be limited and in line with the requirements for confidentiality.

The intake officer will need to consider the cultural background, ethnic origins, means of communication and level of comprehension of the consumer and family to ensure a comprehensive intake assessment that provides meaningful information and an allows evidence-based treatment plan to be developed. .

On the first contact with the consumer the following mandatory assessments should be conducted:

- Mental State Exam
- Risk Assessment
- Family and social supports

In addition, if indicated, an alcohol and drug screening assessment should also be undertaken.

A summary of the information gained via this assessment should then be presented to the multidisciplinary team / cluster to consider a response. It is at this time the referral is either accepted for service or referred on to other services if appropriate. If accepted

for service a case manager is appointed and an initial plan is proposed by the multidisciplinary team.

The case manager is responsible for feeding back the outcomes of the intake assessment to the Helpline for entry onto the consumer contact record on the 'TRIO' data base

### **Engagement with the consumer**

The case manager's first task is to make contact with the consumer to explain the proposed initial plan for treatment, and to give full explanation of the likely outcomes. This includes explaining the alternatives for treatment or care available, to ensure the consumer is able to make fully informed decisions regarding care.

As intake, assessment, case management and treatment are provided by one multidisciplinary team, handover of information between team members should be done face to face, preferably via either a multidisciplinary team meeting or a clinician to clinician discussion. This will ensure communication of all relevant information regarding the consumer is shared in a direct and timely manner, eliminating repeat assessments and ensuring all clinicians from the team have input into the treatment plan and care provided.

### **Assessment**

Following intake assessment and initial intervention the case manager in collaboration with the consumer will use the information from this process *along* with HoNOS, Life Skills Profile, Basis 32 and any additional assessments required to formulate the ISP.

At intake the parental status of consumers is to be established via an assessment of family and social supports. If a consumer has parental responsibilities a plan is to be developed using the Children of Parents with Mental Illness (COPMI) guidelines. This will include involvement of other family members in a collaborative manner to develop a plan to address the child's/children's needs. A flowchart for COPMI guidelines is included in the attachments to this resource.

### **Identifying others involved in care**

Firstly, the case manager with the consumer's consent will identify other people who will be involved in planning care, and these are recorded in the ISP. These may include the consumer's GP, a family member or significant other or other service providers also delivering a service.

### **Consumer's strengths**

Through assessments the consumer's strengths are identified and recorded in the ISP. These include areas such as personal attributes, skills and achievements, interests and aspirations, social networks, groups, family support and other services involved in care. Identifying consumer strengths acknowledges and supports the personal resourcefulness of persons with a mental illness and actively supports the use of community resources available to them. It also opens up discussion regarding what is important to the consumer and what goals they may have for the future, and this will assist with collaborative goal formulation in the ISP.

### **Needs Assessment**

A needs assessment should also be included in the ISP and should cover the broader area of need related to the disability associated with mental illness. The following needs assessment, which has been adapted from the Victorian Mental Health Service, *Needs for Service Categories*, identifies the areas that should be considered when undertaking this assessment.<sup>30</sup>

### **General health**

People who have a serious mental illness have higher rates of physical morbidity and associated mortality than the general population. Often consumers with associated disability will not access preventative health services and may not identify illness and seek appropriate treatment. Some treatments for mental illness lead to long term health risks. Problematic alcohol use and illicit and prescribed drug abuse can also compound health problems.

**Areas to consider include:** physical examination performed annually or at intake, routine screening for high risk areas, access to GP and primary health services.

### **Family needs**

Family and carers often experience distress, turmoil and grief when a family member has a mental illness. Relationships may be tense or completely broken down and family life is often disrupted.

**Areas to consider include:** families response to the consumer, their attitudes to mental illness and seeking help. What knowledge they have of mental illness. Tensions between family members, emotional needs of carers and family, what resources and strengths the family unit have. The degree of support for the consumer has and the level of connectedness or isolation from their community. Special needs of children of a parent with mental illness must also be considered.

### **Social skills**

Social competence has been associated with better recovery from serious mental illness, particularly friendships.

**Areas to consider include:** number and quality of friendships and networks, value placed on these, including the level of enjoyment; Level of comfort or anxiety experienced in social situations; Intimate relationships and barriers to establishing relationships and friendships.

### **Activities of Daily Living (ADL's)**

Considers the consumers ability to live independently and attend to day to day activities. Some consumers are unable to attend to ADL's for short periods of time during acute stages of illness, for others with enduring mental illness problems with ADL's may be ongoing. Some consumers may experience great difficulty relearning these skills even when motivated. The benefits of providing basic support versus assistance with skills (or both) must be considered in the light of the consumers own goals and the likelihood of a positive outcome ongoing. Independent living skills can influence the likely housing and social relations options.

**Areas to consider include:** level of concern or distress and ability to perform ADL's, requirements of others dependent on the consumers such as children or elderly, current skills needed for preferred living arrangements, availability of support options in the formal and informal networks.

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<sup>30</sup> 'Resources for Case Managers ; Individual Service Plans', *Aged Community and Mental Health Division*, Victorian Government, Melbourne, 1998, pp. 6-14

## **Safety**

Safety issues are a primary concern for consumers, carers and service providers, whilst this is covered in risk assessment on intake they need to be considered in more detail in the ISP.

**Areas to consider include:** safety of the consumer's physical and emotional environment, risk or previous risk of physical or sexual abuse by others, high risk behaviors, wandering, inability to manage house hold equipment safely, self harm, suicidal thoughts/acts, and violence towards others. Personal level of autonomy/independence versus dependency may need to be considered. The safety and emotional security of children of a parent with a mental illness also needs to be considered.

## **Vocational and educational**

Purposeful activity is a highly valued goal raised constantly by consumers. Employment and career options are often limited for people with a mental illness because of the episodic nature of illness and the recovery and the stress involved in maintaining full-time employment and or studies.

**Areas to consider include:** needs for employment prevocational programs, rehabilitation programs, education and meaningful enjoyable activities.

## **Rights, Advocacy and Legal needs**

Because of the level of social and economic disadvantage experienced by people with mental illness, considering their rights and needs for advocacy is important to achieving improved outcomes. Linking the consumer with support groups and/or advocates may assist individuals to overcome disadvantage and discrimination.

**Areas to consider include:** information about advocacy groups, rights in relations to health care, income security and tenancy and choices available to them. The need for Guardianship and Administration and/or treatment under the Mental Health Act.

The ISP should document needs identified from the above assessment. If a significant need exists, it may be necessary to undertake a further specialised assessment. For example activities of daily living, and level of functioning assessment, upon which an ISP may focus.

## **Planning**

### **Prioritising care**

Every consumer will have a plan prepared based on the information gathered from the above assessments. There may be many areas of unmet need, identifying these in a collaborative way with the consumer will pave the way for agreement on the priorities for care.

The ISP documentation suggest no more than **three areas of need** are to be addressed at a time. This is to ensure interventions are targeted at priority needs; these are detailed and are achievable. Priority areas of need identified should also reflect the HoNOS scores Interventions addressing a priority needs may impact positively on other areas of need. At each point of review all areas of need are re-considered in planning the next component of care.

Priority areas of need are to be documented in such as way as to clearly state the goals or issues to be addressed, summarises the interventions provided, identifies the person

responsible and sets a review date.

ISP should also include a 'relapse plan', agreed by all involved i.e. the consumer, carers, case manager, other service providers and the GP. The carer's role in relapse prevention is often critical as they may be able to recognize early warning signs of relapse and initiate an early response. Case managers (with the consumer's consent) should involve and support carers in this role.

The case manager is responsible for ensuring that the ISP meets appropriate clinical standards. Interventions planned are to be evidenced based and endorsed by the multidisciplinary teams where the plan must be written in English. A copy of the plan should be provided to the consumer/legal guardian. With the consumer's consent a copy should also be made available to outside agencies, or services involved in the consumer's care.

The case manager, and any other clinician on the multidisciplinary team, may initiate changes to the ISP based on any ongoing assessments, or significant changes in the consumer's presentation or situation. Consumers may also request or negotiate change to the ISP. Significant changes to an ISP must be endorsed by the multidisciplinary team.

Where there is a significant disagreement about the content of the consumer's ISPs from the consumer or family, the case manager is responsible for negotiating an agreement in consultation with the multidisciplinary team.

Any dispute between MDT members regarding the formulation, implementation, monitoring or evaluation of an ISP will be addressed by the team leader.

### **Implementing**

The case manager is responsible for ensuring the implementation of the ISP. Implementation consists of carrying out the strategies devised in the ISP to achieve the goals that have been agreed with the consumer. To achieve this, the case manager will need to:

- Liaise and consult with other services such as NGOs GPs and primary health services to ensure the effective and efficient coordination of service delivery
- Provide information and support to family and carers
- Work collaboratively with the consumer
- Provide accessible service through outreach and home visits where required
- Follow up on missed appointments
- Be prepared to adjust the plan as required

This process should lead to effective implementation of the ISP.<sup>31</sup>

### **Monitoring and Review**

Monitoring is an ongoing process undertaken by the case management at each contact with the consumer, as well as set regular reviews with the multidisciplinary team. The maximum period between reviews is 3 months. The team leaders are responsible for ensuring reviews take place as scheduled within the specified time frames.

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<sup>31</sup> Victorian Mental Health Service. *op.cit.*, p. 26

For the consumers ongoing monitoring and review will ensure:

- Ongoing assessment of need occurs and new issues are identified
- Urgent needs are identified and attended to
- Services being used are effective and appropriate
- Input and support are matched to needs
- Any discrepancies between assessed need and service provision can be addressed as quickly as possible
- Services are discontinued when no longer required

Each consumer's progress will be formally reviewed at regular intervals, in an acute stage this may be weekly and for those receiving maintenance care at least every three months. The case manager will be responsible for coordinating the review of the ISP and its implementation. At this point, the extent and nature of met needs and unmet needs is established and forms the basis for decision making regarding additional or ongoing care.

The format of each review may differ from consumer to consumer, reflecting the individual needs of the consumer concerned. The views of others involved in providing services to the consumer should be sought in order to provide an accurate monitoring of programs and outcomes of care to assist in collaborative practice. A formal review with the multidisciplinary team must occur every three months and should, where possible, include the endorsement of the approach to care by the Consultant Psychiatrist. As part of this review the HoNOS, Basis 32 and Life Skill Profile assessments are to be conducted and considered along with the identified issues and goals listed in the ISP.

One of the following three decisions can be made at review, in conjunction with the consumer and their family and other carers, where appropriate and consented to:

### **Continued Monitoring**

The strategies and goals identified in the ISP continue, with ongoing monitoring of their effectiveness.

### **Change in Treatment**

A change to treatment is based on changing, emerging or unmet needs of the consumer. These are determined from updated assessments and reviews. Not all consumers will respond to standard treatment regimes, alternative treatment strategies will need to be considered when standard treatments have failed. It is vital to involve the multidisciplinary team in determining any changes to treatment to ensure alternatives also meet standards of care are endorsed by the multidisciplinary team and can be delivered by appropriately skilled practitioners.

### **Case Closure and Transfer of Care**

Case closure or transfer of care occurs when the consumer's service needs have been met, and or they no longer require specialist Mental Health Services and their needs can be met appropriately by services outside public Mental Health Services.

### **Discharge Planning and Transition of Care**

Promoting discharge at intake demonstrates a commitment to recovery for the consumer and empowers the consumer to take steps towards this.

'Ensuring consumers and carers are aware that care will be provided for the period of time clinically indicated, are important, and will ensure consideration of other services occurs when intensive or specialist mental health care is no longer required. Mental illness may be recurrent or result in chronic symptoms. This should not preclude consideration of discharge to non-specialist or non government health services. Discharge planning requires input from all levels of the multidisciplinary team, from the individual clinician, team leader and the consultant psychiatrist, in considering the required level of service, who should provide that service and alternative service providers'.<sup>32</sup>

The process for discharge planning commences at admission where goals for care and discharge are determined.

It has been noted that some consumers remain in contact with Mental Health Services whom, 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, being primarily provided by the consumer's GP, private psychiatrist or NGO support services. To achieve this, the case manager works collaboratively with the services to ensure the consumer's needs are met. Mental Health Services should be structured to enable flexible entry and exit from specialist services to the primary care sector, as do other areas of specialised health care. It should be emphasised a person may always return to the service should it be clinically indicated.

As a consumer moves towards recovery, discharge plans should be discussed at each scheduled review. Discharge plans should include ongoing needs and how they are to be provided for. For example supported accommodation, or ongoing medication needs and referral to engage other services to provide these should be made. Involving these services in a collaborative way in finalising plans for discharge is important to ensure the appropriate transfer of needs is communicated.

Relapse prevention plans need to be established and should clearly identify early warning symptoms of illness reoccurring, with proven strategies to address these. The relapse plan would detail who is to be involved in relapse prevention, e.g. GPs, family carers, after hours services and or the case manager. The plan should extend to what to do if they are unsuccessful, e.g. who to contact for further assistance and how to re-engage Mental Health Services, if required.

Relapse prevention plans may be part of ongoing care for consumers with serious mental illness or are developed as part of the discharge planning process for all consumers.

It is also essential that a current copy of the relapse prevention plan is forwarded to the Mental Health Helpline.

## **Discharge should be considered when**

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<sup>32</sup> *Discharge Planning for Adult Community Mental Health Services*, Aged and Community Health Division Victoria, Office of the Chief Psychiatrist, Melbourne, 2002, pg 2.

- The consumer has not received services from the CMHT within the previous three months.
- The consumer does 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 the consumer's GP or other primary health care service providers or other support agencies.

## **Transition**

Discharge is a crucial transition point and unless carefully managed there is a risk that the individual's ongoing treatment and care may be adversely disrupted. When a consumer who has had extended contact with Mental Health Services is discharged, a transition period should be established. During this time the case manager is to remain in contact with the consumer until they have effectively engaged with the new service provider, providing support to both the consumer and the service provider.

Discharge planning documentation should reflect the following:

- Discharge planning commenced on admission to the service
- A comprehensive clinical review and consultation with the consumer and carer has been undertaken prior to discharge
- The treating team has reviewed the discharge decision
- Necessary referrals have been undertaken
- Discharge has been formalised in writing with a discharge summary and follow up actions clearly indicated to relevant providers
- Discharge has been communicated to the Mental Health Helpline.

At discharge the consumer, carer (as indicated) and any relevant service providers are advised how to re-access the service if necessary in the future, and have been provided with the number of the Mental Health Helpline and other relevant emergency contact numbers as required..<sup>33</sup>

A standardized discharge plan is part of the documentation suite which Mental Health Services has a strategic commitment to eventually introduce at the state-wide level.

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<sup>33</sup> *Ibid.*, p. 7



## **Attachment List:**

Tasmanian Mental Health Services Strategic Plan

Case Management Society of Australia's 'National Standards of Practice for Case Management'

Blue prints - Adult Community Mental Health

Blue prints - Adult Inpatient and Extended Care Mental Health

Blue prints - Older persons Mental Health

Blue prints - Child and Adolescent Mental Health

Case Load allocation discussion Paper

Draft Case Load Assessment Tool

HoNOS assessment scale

Life Skills Profile assessment (LSP-16)

Basis 32 Assessment

KIDS in Mind Policy and guidelines

Chronic Disease Management

# GLOSSARY

## **Term**

Appropriately qualified experienced mental health professional

## **Definition**

An individual with recognised qualification and experience, which enable them to provide appropriate treatment and support to the consumer and their carers.

(National standards for mental health standards 1996)

Assessment

The systematic and ongoing evaluation of information about a consumer in order to ascertain his/her diagnosis needs and desired outcomes of care. Assessment forms the basis for the development and review of an Individualised Service Plan (ISP) in collaboration with the consumer, their family, carers and significant others.

(National standards for mental health standards 1996)

Basis 32

Behaviour and Symptom Identification Scale – 32, item primarily a consumer self-rating scale that measures symptoms and disabilities.

Care

All services and interventions provided to a person with a mental disorder and/or mental health problem by health and other sectors, community organisation, family and others.

(National standards for mental health standards 1996)

Care Pathway

Formally articulated mapping of services provided within and across sectors and with agreed streamlined entry/exit procedures that support continuity of care by ensuring that consumers of services are able to negotiate the system in a seamless and timely manner.

(National Mental Health Plan 2003-2008)

Carer

Relatives or friends who voluntarily look after individuals who are sick, disabled, vulnerable or frail.

Case management

The mechanism of ensuring access to and coordination of the range of treatment and services necessary to meet the identified needs of a person within and outside the integrated mental health service.

(National Mental Health Plan 2003-2008)

Case manager

An identifiable and accessible staff member of the mental health service who is responsible for the coordinating the treatment and support provided to an individual consumer and their carers.

(National standards for Mental health Services)

Clinical governance

System for ensuring clinical standards of care

Consultation-liaison Services

Formal support and clinical guidance provided by specialist mental health care to other providers, including general practitioners.

Continuity of Care

The provision of a barrier- free access to the necessary range of health care services, across hospital, community and other support services, over any given period of time with the level of support and care varying according to individual needs.

Discharge Plan	A plan to prepare consumer for discharge or exit from Mental Health Service. It includes the goals to meet prior to discharge, identification of ongoing needs and referral or transfer processes to alternative services.
Early intervention	Timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of patients suffering form a first episode of disorder. (National Mental Health Plan 2003-2008)
HoNOS	Health of the Nation Outcome Scales – primary clinical rating scale designed to measure the physical, personal and social problems associated with mental illness. This is completed on admission review and discharge.
HoNOS-CA	Health of the Nation Outcome Scales for Child and Adolescents version.
HoNOS65+	Health of the Nation Outcome Scales for Psychogeriatric version.
Initial contact	The first time the consumer makes contact with the mental health during any episode of care. (National standards for mental health standards 1996)
Intake & Assessment	Formal process of assessment and data collection to determine the consumers needs for treatment and or service on entry to the service.
Integrated mental health Service	A mental health service which brings together a number - of components into a unified system which ensures continuity of care for consumers: - unified management system between inpatient and community services - a case management system - a single point (or process) of entry into the service - multidisciplinary teams - active involvement of consumers and carers - specialist crisis intervention, assessment, acute care, ongoing care and rehabilitation care across the consumers lifespan. (National standards for mental health standards 1996)
Individual Service Plans (ISP)	Documented set of goals collaboratively developed by the consumer and the case manager. The individual service plan sets the direction for treatment and support, identifies necessary resources, and is responsible for various components and specific outcomes for the consumer. It is recorded in the consumer’s individual clinical recorded with a copy made available to the client and others involved in care – where consented to.
In-reach	Case managers maintain contact with clients whilst in hospital, (in-reach) contributing to treatment plans and in consultation with

	hospital staff undertakes discharge planning.
Links	The formal and informal aspects of the relationship between the mental health service and another service provider, agency or sector. (National standards for mental health standards 1996)
LSP-16	Life Skills Profile, 16 item – a clinician rated scale of disability for use in community service settings.
Multidisciplinary Team	The identifiable group of mental health personnel comprising a mix of professionals responsible for the treatment and care of people with mental illness. (National Mental Health Plan 2003-2008)
Primary care sector	Primary health care and support Services e.g., General practitioners, Mainstream health services, non government organisations i.e. supported accommodation.
Proactive approach	A proactive style of case management which promotes engagement of reluctant consumers, close follow up for new fragile consumers and responsive management of consumers with enduring mental illness.
Recovery orientation	A model which assists the person with a mental illness to return to a meaningful and productive role within their community regardless of any limitations resulting from their illness.
Share Care	Care provided collaboratively by general practitioners and specialist mental health care providers or y public sector mental health services and private psychiatrist. (National Mental Health Plan 2003-2008)
Single point accountability	Every staff member within MHS has a responsibility to ensure the delivery of quality care at all levels of the organisation. Case managers will be accountable for consumers they work with and provide a central point of contact. Teams leaders are accountable for the performance of the Team in overall service delivery and Managers are accountable for the achievement of organisation goals.
Strengths model of case management	An approach which focuses on the strengths rather than pathology, with a belief that people with a serious mental illness can continue to learn, grow and change. The relationship with a case manager is essential, there is an emphasis on goal setting and intervention based on the consumers self determination with high level of consumer input.
Strategic Plan	A plan that is organisation-wide, establishes an organisations overall objectives; and seeks to position the organisation in terms of its environment. (National standards for mental health standards 1996)
Support	Direct services and interventions provided to a person with a mental disorder and/or mental health problem and associated disability aimed at reducing handicap and promoting community tenure (e.g.: assists with cooking and cleaning). Support services do

not necessarily have a treatment or rehabilitation focus.  
(National standards for mental health standards 1996)

Treatment

Specific physical, psychological and social intervention provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.  
(National standards for mental health standards 1996)

Therapies

The range of therapeutic approaches which reflect best available evidence and used in mental health care (excluding medication and other medical technologies). (National standards for mental health standards 1996)

Triage

A system for determining the relative priority of new referrals. The principles of any triage system is for the right person to be directed to the right place at the right time for the right reason

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