

Discharge planning and the development of protocols between adult area mental health services and general practitioners

Background paper

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Published by the Mental Health Branch

Victorian Government Department of Human Services, Melbourne Victoria

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This document may also be downloaded from the Department of Human Services web site at: www.health.vic.gov.au/mentalhealth/publications/discharge-planning.pdf

Printed by Documents on Call, 2B Parker Street, Footscray Victoria 3011

June 2005

(050509)

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1. Background to the need for increased collaboration between area mental health services and general practitioners

Introduction

All sectors of the public and private mental health systems have a part to play in assisting people with a mental illness. A proportion of people in Victoria with a mental illness, particularly a severe mental illness, are treated in area mental health services (AMHS). As individuals' needs change, they may be transferred to other health service providers. It is crucial, therefore, that adequate planning occurs at the point of transfer with the participation of the consumer and other relevant stakeholders, and that information concerning their mental health is imparted to the patient's health care provider. This document considers the transfer of care from AMHS to general practitioners (GPs) for ongoing treatment.

The vast majority of people with a mental illness now live and receive their care in the community through a variety of health, mental health, community and support services. The carers of people with a mental illness also support the recovery and care process. GPs are a key component of this broad mental health workforce. It is estimated that GPs assist 75 to 90 per cent of patients with mental illness in the community, across the full range of illness severity (Keks, et al., 1997). While depression and anxiety disorders are among the most common problems managed within general practice, GPs provide 30 per cent of the services to people with severe mental illness, particularly psychoses; 30 to 40 per cent of people with chronic psychoses see only their GP (King, 1993 cited in Keks et al., 1997; Meadows, 2003).

Both the Second National Mental Health Plan (1998) and the National Mental Health Plan 2003–08 (2003) encouraged the development of the mental health role of a range of service sectors, particularly among primary care providers such as GPs. A number of recently-implemented Commonwealth and State mental health initiatives have aimed to further enhance the role of the GPs in mental health care and improve their links with other providers. These include the Better Outcomes in Mental Health initiative and the Enhanced Primary Care initiative at a Commonwealth level, and the Primary Mental Health and Early Intervention initiative by the Victorian State Government (appendix 1). Collectively, they endeavour to increase GPs' knowledge of mental health issues and their ability to manage them.

Medicare now provides funded opportunities for GPs to engage in the shared care arrangements with AMHS for people with complex health needs or a chronic illness that includes a mental illness, or to engage in discharge planning when the GP assumes full care. From the AMHS perspective, the evolving caseload management system (appendix 1) has implications for discharge planning. One of its aims is to enhance outcomes for people with a mental illness through a more active review of their needs. For many consumers there will come a point at which their GP becomes the most appropriate professional to treat and manage the illness. High quality discharge, support and re-entry processes are essential to bridge the transfer.

Discharge planning standards and guidelines

Discharge planning is a part of the process of care for all consumers in AMHS. Both the Discharge Planning Standard within the *National Standards for Mental Health Services* and the Victorian Chief Psychiatrist's guideline, *Discharge Planning for Adult Mental Health Services*, outline the range of criteria that contribute to consumer-centred discharge planning (appendix 2). Together, they identify two types of discharge planning actions that concern:

1. the consumer and the AMHS
2. the consumer, their carers, the AMHS and other providers, such as GPs.

It is issues relating to this second group of stakeholders that should be included in a protocol between an AMHS and a GP division or practice.

This paper builds on the foundation of the Discharge Planning Standard and the Victorian Chief Psychiatrist's guideline. The focus of this paper is:

- the contribution of the Mental Health Branch (MHB) to discharge planning through improving overall capacity
- the development of discharge protocols for transferring people from AMHS, particularly adult community mental health services, to GPs to ensure that the quality and continuity of care are maintained.

The protocols apply to people involved in the AMHS both in the medium to longer term as well as those who enter the AMHS via a short-term, inpatient admission and are then discharged to GP care.

2. Enhanced capacity and discharge planning

The 2004-05 Victorian Government budget provided funding for additional community mental health clinicians to support discharge planning within adult mental health services. Depending on an AMHS configuration, these new positions may also be used to strengthen an AMHS-wide function, or operate as part of a team that supports discharge planning and follow up. It is not expected that these new positions will operate in a stand-alone capacity.

It is expected that the new positions will be located in a core component of AMHS that already has a significant interface with GPs, which in most instances will be the continuing care team (CCT). Some AMHS may choose to include a position in the primary mental health and early intervention (PMHEI) team. Where linked to PMHEI teams, this additional resource is expected to build on the PMHEI team's existing function of providing education and consultative services regarding low- prevalence disorders to GPs (Mental Health Branch, Department of Human Services 2000).

It is worth noting that the 2004-05 Victorian Government Budget also includes funding for additional positions in a number of inpatient units. These positions are expected to lead to improved discharge planning, coordination and outcomes. While services will be required to ensure continuity of care between acute inpatient services to continuing care units (CCU), prevention and recovery care (PARC) services, mobile support and treatment (MST) services or CCTs operated by the adult mental health service, AMHS should also consider how these positions will enhance continuity of care between inpatient services and GPs where discharge from an inpatient unit to a GP occurs.

From an organisational perspective, discharge planning aims to:

- improve the continuity of care for consumers moving between specialist mental health services and GPs
- enhance the organisational links and communication between specialist mental health services and GPs
- provide support for GPs in their management of people with chronic mental illness
- support change brought through the caseload management system.

In the process of improving discharge planning, services are encouraged to further develop other aspects of the GP/mental health service interface. These aspects include referral (entry and re-entry) pathways and shared-care arrangements for consumers, who could benefit from the concurrent involvement of specialist mental health services and GPs.

3. Guidelines to the development of protocols and improved discharge planning

Area mental health services may need to revisit their existing discharge planning policies and procedures, and establish protocols with GP divisions or GP practices where they do not exist. While the local implementation process can develop protocols relevant to their local context, each protocol must address the key issues outlined in this section.

Protocol development

Each AMHS will be responsible for improving discharge planning and developing a local discharge protocol, which will outline the agreed process for the transfer of care between specialist mental health services and GPs, including discharge, support and re-entry processes; existing organisational structures within AMHS can be used to further progress these issues. Input should be sought from consumer and carer representatives, along with representatives from local GP divisions and AMHS. Where there is more than one GP division within an AMHS, it may be feasible for the divisions to choose one of their number to take the lead role in developing a protocol by virtue of their size, interest in mental health or because they do not overlap with another AMHS. The AMHS may use its existing PMHEI team steering group to undertake this role, but must also include the CCT.

In the absence of an appropriate structure within the service that can draw upon the aforementioned representatives, a working party could be convened for a limited period to instigate improvements to discharge planning processes and develop a protocol. While initially improved discharge planning targets consumers obtaining services from adult AMHS, it is anticipated that the process will provide a discharge-planning framework that may be applicable to child and adolescent mental health services and aged person's mental health services; therefore, the participation of representatives from these services is encouraged. It should be noted that where primary care partnership systems and practices are in place, discharge planning processes should be integrated with them. The MHB has recently released guidelines for the participation of AMHS in the primary care partnership service coordination strategy. The guidelines are on the MHB website: www.health.vic.gov.au/mental-health/pub.

In addition, all protocols should integrate those aspects in the Enhanced Primary Care (EPC) and Better Outcomes in Mental Health initiatives, which can contribute to improved discharge planning. EPC provides funds for GPs to participate in discharge planning and similar processes. The protocol could propose solutions to the impediments that are preventing GPs from engaging in the process; for example, AMHS staff could consult with GPs regarding convenient times for discharge planning, whether face-to-face or by telephone conferencing. Also, AMHS staff should understand the requirements of the EPC items so as not to disadvantage GPs in engaging in case conferencing.

Better Outcomes in Mental Health (BOMH) aims to enhance GPs' abilities to manage consumers with a mental illness and to access other health professionals. There may be some AMHS clients nearing the point of discharge who would benefit from time-limited allied health intervention in addition to GP care after discharge. Engagement in BOMH could form part of the discharge plan. In order to inform GPs and consumers, the discharge planning protocols could outline the relationship of the AMHS to other mental and general health services and their respective roles. As a starting point, appendix 3 summarises the services and their functions typically available in an AMHS.

Comprehensive discharge planning

Discharge can be a time-intensive aspect of case management. The presence of supportive processes and systems, similar to those in shared care, can only improve discharge planning and is a valuable investment in time and resources by the AMHS (Pirkis et al., 2004).

While empirical evidence for specific models of discharge planning is lacking, a number of good practice principles have been highlighted. Effective discharge planning is a structured process that should be initiated from an early stage of contact with all new service users (Office of Chief Psychiatrist, 2002). It requires the active involvement of consumers and carers, and close cooperation between all relevant service providers (Department of Health 1989, cited in Simons and Petch, 2002).

Other key requirements for effective discharge planning include a period of adequate preparation and pre-discharge liaison, good communication and information sharing (Yung and Grigg, 2000), the coordination of the discharge process by 'a skilled, named nurse' (Taraborrelli et al., 1998, cited in Simons and Petch, 2002), and good documentation. This documentation should include a written discharge care plan detailing the post-discharge care coordinator, the treatment to be provided and a crisis action plan (Department of Health 1999, cited in Simons and Petch, 2002).

These practices can be summarised into four key areas of discharge planning, which are the responsibility of the AMHS. They also overlap with the criteria mentioned in the *National Standards for Mental Health Services* and the Chief Psychiatrist's Guideline:

1. engage in collaborative discharge planning at an early stage of treatment with the consumer, their carer/s, key AMHS and external stakeholders involved in the consumer's treatment and care
2. provide written and verbal treatment-related information for the consumer being discharged and their carers
3. provide written and verbal treatment-related information for GPs and other service providers involved in the consumer's care
4. provide timely communication with consumers, carers, GPs and other key stakeholders.

Similar practices were found to positively contribute to discharge outcomes in hospitals during the Effective Discharge Strategy (2003). The stakeholders referred to above may include AMHS multidisciplinary staff, private psychiatrists, GPs, PDRSS and other health or community service staff. Although one AMHS staff member is usually the key contact for the GP regarding a given consumer, other multidisciplinary clinical staff should contribute to the discharge planning as appropriate.

The Mental Health Branch proposes that discharge to GP care proceeds through the following phases:

- (a) preparation
- (b) implementation/transition
- (c) full GP care

Each discharge protocol will need to address the issues outlined below. Note that the Consultation and Liaison in Primary Care Psychiatry (CLIPP) Manual provides a useful resource when developing GP discharge protocols and is available at www.health.vic.gov.au/mentalhealth/publications/clipp/index.htm.

(a) Preparation phase

The ultimate purpose of discharge planning is to maximise the prospects for moving the consumer's recovery forward. A discharge plan is:

- an information exchange tool and a management plan, including the management of risk
- a contract between respective stakeholders that defines expectations, roles and responsibilities.

The preparation phase includes the following three stages:

1. Identifying consumers and assessing suitability for discharge

Services will need to develop agreed criteria for determining those consumers whose ongoing needs can be met by transferring their continuing care to a GP. The two most obvious groups are people who only require medical management and those who have been stable over a reasonable period of time. The caseload management system used by a given AMHS or the consumer's score on outcome measures may also indicate that the consumer is ready for discharge. As a general rule, consumer's symptoms should be well controlled, they should preferably be motivated to continue treatment and live in a stable, supportive psycho-social environment, which includes stable accommodation.

The decision to initiate the discharge process takes place within the context of existing internal multidisciplinary case review processes in each AMHS, which should be headed by a consultant psychiatrist. For a variety of statutory, treatment-related or practical reasons, there will be some consumers who will not be able to have their continuing care needs fulfilled by a GP, and will need to remain with the AMHS indefinitely or for an extended period of time. In such instances, AMHS should monitor the potential for discharge and focus clinical and other interventions on what needs to be achieved in terms of the consumer's illness or behaviours for discharge to be considered.

As far as possible, transfer to GP care should not lead to significant financial or practical burdens being placed on the consumer or their carer. In some areas, client access to GPs or bulk-billing GPs may be limited. This will restrict the number of patients who can be fully discharged from AMHS to GPs. Extended shared care arrangements may be more common in areas of GP shortage.

2. Consumer and other stakeholder involvement

The consumer-centred nature of discharge planning necessitates the consumer's involvement in the communications concerning the discharge process. To the extent possible, it would also respect and accommodate the consumer's values, preferences and expressed needs (Cott, 2004). The discharge plan takes account of the consumer's strengths and their support networks, both formal and informal.

Carers need to be involved from the start. Where appropriate, the AMHS case manager should negotiate the extent and type of family involvement. If the person with a mental illness withholds consent for information to be provided to a carer, the AMHS needs to proactively manage this in a manner sensitive to all parties and with an awareness of the legislative provisions of the *Mental Health Act 1986*, particularly section 120. Carer willingness and ability to contribute, as well as their education and support needs, should be part of the assessment process.

A number of people with a mental illness have other psycho-social problems. Difficulties such as inadequate employment and nutrition have long-term consequences for the person with a mental illness. If not already involved, the case manager may need to contact drug and alcohol, accommodation, psychiatric disability rehabilitation support services (PDRSS), or other forms of psycho-social support before the consumer's discharge from the AMHS. In fact, the acquisition of skills to manage interpersonal and social relationships has been shown to be important in helping the person to feel able to participate in the community and avoid isolation (Cott, 2004).

3. Liaison with the GP

In discharge planning, as in shared care arrangements, there will be varying roles and levels of responsibility for GPs and AMHS staff depending on the consumer's needs and the GP's skill base (Keks, et al. 1997; Alliance for NSW Divisions, 2003). When framing the responsibilities for AMHS and GP involvement, however, these should be guided by what can reasonably be expected by the services. The discharge plan needs to clearly express why continuing case management is no longer applicable to the consumer.

Every AMHS client should be linked to a GP wherever possible. As such, each AMHS will need to develop strategies to identify and document a consumer's GP on their registration sheet and relevant care-planning documentation. As some consumers will not have a regular GP, or move from practice to practice, each service should also introduce strategies to encourage consumers to engage with one GP or practice.

Although continuity of care in this paper refers to processes between services, care continuity within a setting can positively contribute to health outcomes. In primary health settings, it has been found that care by a consistent GP improves the quality of care for people with chronic conditions, reduces hospitalisations and emergency department visits (Cabana and Jee, 2004).

Once all parties have been approached, the process of developing a discharge plan may commence.

(b) Implementation/transition phase

Discharge is a staged process in which care is transferred to the GP while involvement from the adult AMHS gradually decreases. Following the development of the plan, the formal process of discharge may commence. The transition period will vary in nature and length according to the history and care needs of the consumer. A transition phase may be required for people with complex needs before it is ascertained that the GP can fully support them. People who have received extensive care from a specialist mental health service may require a transition of up to 12 months.

For this group, it is expected that a number of planned contacts from the AMHS will occur with the consumer and their GP, whether face-to-face or via telephone. Planned contact should occur within a month post-discharge and as required thereafter, with a review at the end of the transition period. In addition, arrangements for unplanned contact will need to be specified in the discharge plan as discussed above. The review should involve face-to-face contact with a consultant psychiatrist, registrar or medical officer, and the discussion

can be informed by outcome measurement data. Problems arising during the period of transition may require earlier consultant psychiatrist review, followed by case conferencing and review of the discharge plan.

Following this review, the relevant AHMS staff and the GP should decide whether to proceed to full GP care, extend the transition phase, implement shared-care treatment arrangements, or re-engage the consumer back into an AMHS.

(c) Full GP care

The GP's involvement with a consumer is determined by the person's level of need. If the consumer's mental illness has resolved, then the GP's role is to monitor their mental health as well as assess and manage any physical health needs. If the consumer has ongoing mental health difficulties, the GP treats both mental health and other health issues. The ability to assume full care will be enhanced when, as part of the discharge planning process, the GP:

- collaborates with all stakeholders in developing the discharge plan
- is actively involved in the ongoing management of the consumer
- participates in the planned meetings with the AMHS and the consumer during the transition phase
- assumes the provision of medication as appropriate, with reviews as the consumer's condition or needs change; this may include medication review by the AMHS psychiatrist at the GP's request
- is sensitive to the consumer's ability to pay (adapted from The Geelong Division of General Practice and Barwon Health: Community and Mental Health, 2003).

If the consumer's needs appear to change post discharge, and their existing plan becomes inappropriate to their needs, the GP can seek assistance or advice from the AMHS.

Generally, AMHS should accept a GP-initiated referral of consumers discharged within six months and who have received comprehensive care over an extended period of time from the specialist mental health service system. Where the AMHS is concerned about the suitability of such a referral, negotiations need to occur between the GP and the specialist mental health service.

Experience suggests that many people discharged from an AMHS in a stable condition can remain so; however, a crisis may discourage or prevent them from visiting the GP, which may eventually lead to a relapse. GP practices are usually not set up to monitor patient attendance. GPs should consider a strategy to periodically check former AMHS clients so as to prevent avoidable relapses.

Content of a discharge plan

A discharge plan should address issues such as the extent of an AMHS liaison role to the GP and providing direct support to consumers and GPs during the implementation (transition) phase. Sometimes it may be necessary to outline how to provide an assertive outreach response for consumers at risk of treatment 'drop-out'. In some instances, the plan may benefit from a summary flowchart with a hierarchy of response options, with clear criteria for triggering each step.

Discharge plans include summarised details about:

- the consumer's past and current psychiatric history, including any risk factors and the current extent of recovery
- past and current biopsychosocial treatments and their responses
- treatment goals and a recovery plan, together with management recommendations
- early warning signs of relapse and risks, such as frequent missed appointments or the re-emergence of symptoms
- medical and non-medical strategies for managing early warning signs, including whom to contact if a relapse is suspected
- the consumer's involvement with other agencies or service providers
- the support that will be provided by the AMHS to each GP
- a brief statement of the consumer's and carers' knowledge of the condition and the management, including treatment adherence and self-management
- contact details of key workers and, where appropriate, carers
- information about how to re-refer in situations of psychiatric crisis, or to obtain a second opinion.

Each protocol will need to include a copy of the discharge plan proforma that will be adopted by the AMHS. The discharge plan should be kept in the consumer's mental health file and a copy of the plan must be provided to the consumer, their GP and, subject to the consent of the consumer, their carers.

4. Monitoring improvements in discharge planning

Each AMHS will assess their performance with respect to discharge planning, identifying those areas that require improvement. It is the responsibility of the AMHS to formulate a strategy to enhance their discharge-planning processes. This may involve enhancements to staff education about discharge planning, appropriate documentation and support structures within the organisation, information for patients and carers regarding discharge and transition planning, and the means by which information is passed onto GPs. The performance measures for these changes will be particular to each service.

There are overarching indicators already alluded to, namely, the provision of timely patient assessment for discharge, the provision of timely discharge information to relevant parties and follow-up during the implementation phase of discharge. These indicators can be audited periodically within the organisation as part of the quality improvement process. The Mental Health Branch anticipates that the discharge-planning reporting requirements will form part of those identified for the caseload management system. This includes considering key performance indicators such as a reduction in unplanned re-admissions to the AMHS.

The overall intent of discharge planning is to improve service and health outcomes for people with a mental illness. AMHS have existing resources and knowledge concerning discharge planning, which will be enhanced with further attention. The protocol and any changes to the discharge planning process should be periodically reviewed by all stakeholders and adjusted as needed. Collaboration between AMHS on discharge planning and related matters is to be encouraged to share resources and information. This can only serve to strengthen practice across the state.

Appendix 1

Better Outcomes in Mental Health Care

The Better Outcomes in Mental Health Care initiative is funded by the Commonwealth Government to support GPs in the provision of quality care to Australians with a mental health disorder, through the provision of mental health education and training for GPs, and more support from allied health professionals and psychiatrists. The initiative has five major components:

1. Education and Training for GPs—to familiarise GPs with the initiative and to increase the mental health skills of GPs
2. The 3-Step Mental Health Process—a service incentive payment is provided to encourage effective management of mental health problems by GPs through a 3-step mental health process that includes an assessment, a mental health plan and a review
3. Focused Psychological Strategies—to encourage appropriately trained GPs to provide evidence-based focused psychological strategies through the provision of Medicare benefits schedule rebates
4. Access to Allied Health Services—to enable GPs to access psychological and other allied health services to assist patients with mental health disorders
5. Access to Psychiatrist Support—to better enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to provide timely patient management advice (http://www.adgp.com.au/client_images/7061.pdf viewed 7 August 2004).

Enhanced primary care initiative

In November 1999, the Commonwealth Government introduced a range of Medicare items intended to improve care coordination between general practitioners and other professionals providing care for people with chronic conditions and complex care needs, including those with chronic mental disorders. The EPC initiative provides a framework for a multidisciplinary approach to health care by funding general practitioners to be involved in a range of activities, including:

- multidisciplinary care planning
- multidisciplinary case conferencing
- multidisciplinary discharge care planning and case conferencing (www.health.gov.au, viewed 5 August 2004).

Under the enhanced primary care initiative (EPC), for GPs to be reimbursed for case planning and case conferencing, there must be at least two other health professionals present. In addition and where appropriate, carers can also be an integral part of these processes.

The primary mental health and early intervention initiative

In October 2000, the Victorian Government provided funding for the establishment of a new service type: primary mental health and early intervention (PMHEI) teams. The teams were established across the state, one within each of the area mental health service catchments. The teams were established to improve access to, and the quality of, mental health services provided by both specialist and primary health care providers and to improve the links between the two sectors. PMHEI teams provide a mix of direct service delivery to consumers, along with education, training and consultation support to primary care service providers working with the target client group. While AMHS are the managers of the initiative, a multi-stakeholder steering committee provides a mechanism for inter-sectoral collaboration and improved interagency service coordination. The teams have emerged as an important point of interface between specialist services and general practitioners, and provide a potential avenue for further strengthening the links between the two sectors.

Caseload management system

The implementation of the caseload management system (CSM) is a requirement of Victoria's Psychiatric Services Certified Agreement 2004–07. In this context, the CMS is a system employed to assist with service demand and manage case manager caseload in an equitable and transparent manner. In addition, the CMS must provide for systematic triage, allocation, monitoring, discharge and review. Discharge will be monitored and regular discharge data will be provided to AMHS.

Each AMHS will reach local agreement with the relevant industrial bodies. The agreed system must be the primary method of caseload allocation for all case managers and is based on a number of factors and principles enunciated in the agreement as follows:

- case manager capacity based on ordinary hours using an agreed tool
- case weighting reflecting acuity, complexity and client need
- the clinical and non-clinical commitments of case managers
- the professional development and supervision commitments of case managers
- the skill, competency and experience of case managers
- secondary case management allocation
- regular clinical workload assessment
- mechanism for caseloads to be reviewed between case manager and team/program manager on a weekly or otherwise agreed basis as determined locally.

Appendix 2

Table 1: Discharge planning features contained in the National Standard for Mental Health and the Chief Psychiatrist Guideline

Discharge planning feature/criterion	National Standards for Mental Health: Standard 11.5 Planning for Exit	Chief Psychiatrist Guideline: Discharge Planning for Adult MH Services
The Care Plan, begun at entry to the Mental Health Standard (MHS), includes an exit plan	✓	✓
The exit plan is reviewed in collaboration with the consumer and, with the consumer's informed consent, the carers	✓	
The exit plan is made available to the consumer and, with the consumer's informed consent, the carers and other nominated service providers*	✓	
The consumer and their carers are provided with understandable information on a range of relevant services and supports available in the community	✓	
A process exists for earliest appropriate involvement of the consumer's nominated service provider*	✓	
The MHS ensures that contact has been established for consumer who have been referred to other service providers, and arrangements made for ongoing follow-up are satisfactory to all relevant parties prior to exiting the MHS*	✓	✓
All services provided by the MHS are planned and delivered on the basis of the briefest appropriate contact duration consistent with best outcomes for the consumer; plan also considers likely duration of involvement and issues to be addressed, including active strategies for discharge	✓	✓
The clinical record demonstrates that a comprehensive clinical review and consultation with the consumer (and carers unless otherwise indicated) has been undertaken prior to discharge		✓
There is evidence that the discharge decision has been reviewed by the treating team		✓

Discharge planning feature/criterion	National Standards for Mental Health: Standard 11.5 Planning for Exit	Chief Psychiatrist Guideline: Discharge Planning for Adult MH Services
Service providers, consumers, carers and other agencies involved in the ongoing care to identify early warning signs of relapse that indicate that the MHS should be contacted*		✓
Consumers, carers (unless otherwise indicated) and relevant service providers have been advised on how to re-access the service of necessary in the future and has been provided with emergency contact numbers*		✓
Discharge has been formalised in writing with a discharge summary and follow-up action clearly indicated to relevant providers*		✓
A period of transition to a new service provider can be negotiated+		✓
Necessary follow-up has been undertaken within a reasonable time for the consumer's condition+		✓
The service attempts to re-engage with consumers who do not adhere to planned follow-up arrangements+		✓
Case closure should only occur after the transitional period and successful linking of the individual to the new agency+		✓
Documented policies and procedures exist and are used to achieve the above criteria; discharge planning and case closure policies and procedures are available to guide staff; each service should have clearly documented discharge protocols*	✓	✓
MHS monitors its performance in regard to the above and uses data collected to improve performance as part of a quality improvement process	✓	

* *These discharge planning features/criteria directly concern GPs (or other service providers)*

+ *These discharge planning features/criteria are relevant to a small group of people with complex and long-term intervention needs and whose treatment may be shared by a number of professionals, including GPs.*

Appendix 3

Elements of the general adult mental health system in Victoria

Crisis assessment and treatment services

Crisis assessment and treatment (CAT) services provide twenty-four hour mobile assessment and treatment for people experiencing psychiatric crisis. CAT/triage services aim to prevent unnecessary hospitalisation by providing effective treatment in the least restrictive environment, such as in the consumer's home.

CAT/triage services have the responsibility to screen all inpatient admissions, to provide urgent assessment where hospitalisation is considered an option and to provide crisis resolution, assessment and treatment of acutely mentally ill clients referred to the service. These services are provided by all adult area mental health services across the state and are staffed by psychiatric nurses, psychologists, social workers, occupational therapists, medical officers and psychiatrists. CAT/triage services operate twenty-four hours a day, seven days a week, but are not an emergency service response.

Generally two to three staff are on duty during the morning and afternoon shifts and one staff member on call during the overnight period. Some CAT/triage services, particularly in rural regions, are delivered as part of the general community mental health service. Staff work a combination of rostered shifts and standard business hours, and carry a caseload comprising intensive crisis work and ongoing case management.

Mobile support and treatment services

Mobile support and treatment services provide case management and ongoing intensive treatment and support to people with serious mental illness. MST services operate on an extended hours basis seven days a week. They work intensively with a small group of clients at risk of re-admission due to recurrent serious mental illness and continuing disability. They also provide social and vocational rehabilitation services in the client's own environment.

Community mental health service—continuing care, clinical and consultancy services

The community mental health service (CMHS) element is usually the first point of contact during business hours for access to adult mental health services. Mental health professionals employed by the CMHS provide initial screening and consultancy for people requesting public mental health services and guide the consumer to an appropriate service. They provide case management, assessment, treatment, continuing care, and support for clients with serious mental illness.

Primary mental health and early intervention services

Primary mental health and early intervention (PMHEI) services provide short-term treatment, crisis prevention and assessment services to people with high-prevalence disorders, especially depression and anxiety. They also provide early intervention to young people with emerging psychosis and significant psychological disorders. PMHEI teams also deliver consultation and liaison, and education and training to primary care providers for high and low prevalence disorders.

Acute inpatient services

These services provide voluntary and involuntary short-term inpatient management of the acute phase of a serious mental illness until sufficient recovery allows the treatment to be effectively provided in the community.

Prevention and recovery care services

Prevention and recovery care (PARC) services are offered in a residential setting and are related to acute mental health inpatient units. They are suitable for consumers in acute inpatient settings, and in the community, who do not require acute inpatient levels of intervention but will benefit from more intensive clinical treatment and/or psycho-social/practical support than can be provided through continuing care, MST or CAT services alone. The length of stay in a PARC may vary from one to four weeks. The implementation of this service model is being staged over a number of years.

Residential and non-residential rehabilitation services

Rehabilitation services provide assistance to people with a serious mental illness and associated psychiatric disability to learn or relearn every day skills necessary for successful living in the community. They aim to enhance the client's functioning, self-esteem and independence.

Secure extended care inpatient services

These services provide intensive treatment and support for clients who have unremitting and severe symptomatology together with an associated significant disturbance in behaviour, which inhibits their capacity to live in the community. Clients receive twenty-four hour nursing support.

Residential and non-residential government psychiatric disability rehabilitation and support services

Psychiatric Disability Rehabilitation and Support Services provide psychological rehabilitation and support in a variety of ways to people with psychiatric disability to minimise stress, promote and maintain recovery and improve quality of life. Such services include housing support, day programs, prevocational training, residential services and respite care.

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