

An introduction to Victoria's public clinical mental health services



An introduction to Victoria's specialist clinical mental health services

Department of Human Services
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Welcome to the mental health sector!

Starting a new job is exciting but it can also be daunting. Mental health services are complex environments, and the consumers of these services typically have complex illnesses that require considered attention, treatment and support. The families and/or carers of mental health consumers may also require the support of the service. These complexities are part of the attraction and challenge of working in this area of health.

People joining Victoria's public clinical mental health workforce—whether they are new graduates or experienced workers new to mental health in this State—need to know how the public mental health system works.

This document is intended as an overview of the public clinical mental health sector. It provides essential policy, practice and legal information for day-to-day clinical work across the range of work settings and consumer age groups.

In contrast to some other areas of health care, mental health is not a speciality that relies on high technology equipment. While quality practice is built on sound evidence, working in mental health is about people. The most important technology is the staff: the primary therapeutic tools are the knowledge, skills, attitudes and personal qualities that staff bring to the job and develop through work experience and professional development.

A strong theme in this document is the need for clinicians to work collaboratively with consumers and their families and carers. Partnerships between clinicians are also important. In Victoria's mental health services, clinicians work in multidisciplinary teams to provide comprehensive care. Relatively new clinicians work alongside experienced clinicians to assist in the development of knowledge and skills.

We are proud of the public mental health service system in Victoria and committed to its ongoing improvement. The key to this is ensuring that mental health clinicians can provide the best possible care and treatment for consumers and support for their families and carers.

Welcome to the sector!



Dr Ruth Vine
Director, Mental Health
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Introduction

People with diverse backgrounds and varying levels of knowledge and skills join our workforce and take up roles in many different programs, working with a wide range of consumers, their families and carers.

This document has been developed to assist with the orientation of all new clinical staff entering public clinical mental health services in Victoria. The document is consistent with current national and state policy, practice and service standards, and with the literature on quality practice. It provides summary information and aims to meet the following two broad goals.

Firstly, it is intended to be an introduction to essential information for anyone joining public mental health services in Victoria. While it may be most helpful for new graduates, it also provides information that will be of value to experienced clinicians from other settings, and current mental health staff seeking to update their knowledge.

Secondly, this document is intended as a resource to complement local service orientation training. Service managers, educators and supervisors are encouraged to incorporate the policy principles into training and professional development programs. Early and comprehensive orientation tailored to individual needs is known to have a positive impact on staff safety, recruitment and retention, and practice quality.

Structure

Sections 1–3 introduce the policy and principles underlying the organisation and operation of Victoria's mental health services. This section outlines a typical pathway from initial entry to case closure and discharge, and describes service components and the coordination of care.

Section 4 introduces the legislative framework governing treatment and care, including the *Mental Health Act 1986*. These sections will be of interest to all clinical staff entering Victoria's mental health services for the first time, both newly qualified staff and experienced clinicians from overseas and other services.

The document aims to expose clinicians to language and terms that they will encounter in their work. These key words are highlighted and link the reader to the glossary in **Section 5**.

The document also directs readers to relevant references and websites.

1 Policy and practice frameworks

People with a **mental illness** suffer significant disadvantage in accessing appropriate services, and are vulnerable to exploitation and neglect if safeguards do not exist to protect their rights. The reform of services over recent decades has aimed to redress this inequity and ensure that people with mental illness have every opportunity to live and participate fully in the community.

All levels of government policy and legislation focus on developing high quality mental health service systems that are accessible, responsive to **consumer** need, and which build on evidence of effectiveness. The organisation of **mental health** services and the principles of clinical practice are aimed at achieving these objectives.

Figure 1: National, state and local policies and practice standards



1.1 The national mental health strategy

Australia is internationally recognised as a leader in the reform of mental health services. Its national mental health strategy encompasses the national mental health policy, subsequent plans and related publications. All states and territories are required to work towards the national priorities and to report regularly on achievements.

There have been three national mental health plans to date, providing an excellent history of service evolution and describing ways forward:

1. The first plan (1992–93 to 1997–98) focused on deinstitutionalisation and the move to a community-based mental health system. Mental health services were integrated into the broader health system, including general hospitals and other parts of the health sector. The aim was to improve the access of people with a mental illness to generic health services and to decrease the stigma associated with mental illness. Other themes included a focus on those with a serious mental illness, the recognition and promotion of consumer rights, the provision of support for carers, and the measurement of service performance and consumer outcomes.

2. The second plan (1997–98 to 2002–03) continued the first plan's agenda and broadened its focus to address the growing burden of high prevalence disorders such as depression and anxiety. The plan prioritised mental health promotion, illness prevention, early intervention and relapse prevention. Developing a skilled workforce and encouraging more innovative service models was also emphasised. The plan highlighted the need to strengthen services for specific populations: people with co-existing substance abuse and mental illness (dual diagnosis), co-existing mental illness and intellectual disability (dual disability), and to better coordinate mental health with other health and support services to meet consumers' multiple needs.
3. The third plan (2003–08) continues the commitment to improving services and outlines four priorities: promoting mental health and preventing mental health problems; increasing service responsiveness; strengthening service quality; and fostering research, innovation and sustainability.

These and other mental health policy documents can be found at www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs

1.2 State mental health policy

A number of policy documents have been developed over the last decade to guide service reform. These publications remain important references on the structure, growth and principles of the Victorian mental health service system. Services are committed to providing treatment and care consistent with these 'frameworks' through their funding and service agreements with the Department.

Common themes run through all the policies and frameworks, with implications for how clinicians do their day-to-day work. Examples include: encouraging consumers to participate in their own care: including families and carers as fully as possible: being mindful of cultural and gender issues; and striving for quality in all work undertaken.

Framework for service delivery, 1994–2002

A series of documents for **adult, child** and **adolescent** and **aged person mental health services** described the policy framework for the redevelopment of Victoria's mental health services.

Victoria's mental health service: the framework for service delivery 1994 and *Better outcomes through area mental health services* 1996 described the structure, components of the mental health system and the principles of service delivery.

Guidelines for service delivery were also developed for the three key service components:

- crisis assessment and treatment services
- mobile support and treatment services
- general adult community mental health services.

Improved access through co-ordinated client care described the **case management** approach that continues as a core element in the delivery of specialist clinical mental health services.

New directions, 2002–07

New directions for Victoria's mental health services: the next five years 2002-2007 outlined current and future policy directions based on the following principles:

- priority to those in greatest need
- community-based care, consumer and carer participation
- **continuity of care**
- service quality and responsiveness.

The policy directions are:

- expanding service capacity
- creating new service options
- extending prevention and early **intervention**
- building a strong and skilled workforce
- strengthening consumer participation
- improving carer participation and support.

The role of the Department of Human Services

The Department of Human Services is the largest government department in Victoria and covers key service areas including health, housing, aged care and community services. Its principal responsibilities include funding and/or delivering a range of services to enhance the health and wellbeing of Victorians, with an emphasis on vulnerable groups and those most in need.

The role of the Mental Health Branch

The Mental Health Branch of the Department's Metropolitan Health and Aged Care Services Division is responsible for planning, funding, reviewing and redeveloping **public mental health services**. Roles include:

- establishing new services and service types to address gaps in the service framework
- enhancing service monitoring through the use of key performance indicators and service standards
- strengthening the involvement of consumers and carers in service delivery and development
- improving the quality of service delivery and practice through targeted funding, evaluations and audits, outcome measurement and the continuing refinement and articulation of policies, guidelines and standards for all service types
- workforce planning and development
- integrating activities with other related service sectors (acute health, disability services, drug and alcohol services, child protection, juvenile justice and primary mental health and aged care services).

1.3 Safety and quality framework

Safety and quality is integral to practice in Victoria's public mental health services.

Services and clinicians need to continually seek ways to improve practice and maintain safe environments. The driving principle is that better quality services with safe, effective practice lead to better consumer and carer outcomes, as well as the improved well-being of staff.

The concept of quality is more than simply wanting to do an effective and positive job. Services are required to have processes to support and monitor good practice, promote learning and continuous improvement, and encourage clinicians to reflect critically on their practice.

Key frameworks relating to safety and quality in mental health services are discussed below.

The National standards for mental health services

National standards for mental health services 1996 provide benchmark standards against which services and clinicians can review their practices.

All state, territory and most non-government mental health services are required to be accredited against these standards and to report annually on their implementation. Importantly, the standards assist consumers and carers in identifying service practice expectations. All AMHS participate in an external in-depth review against the *National standards for mental health services* as part of an organisation-wide Evaluation and Quality Improvement Program (EQUIP) Survey.

Eleven standards cover all aspects of mental health treatment:

1. rights
2. safety
3. consumer and carer participation
4. promoting community acceptance
5. privacy and confidentiality
6. prevention and mental health promotion
7. cultural awareness
8. integration of services
9. service development
10. documentation
11. delivery of care from access through to exit.

The National practice standards for the mental health workforce

These standards target the largest professional groups in the mental health workforce - nurses, occupational therapists, psychiatrists, psychologists and social workers. The standards identify the core knowledge, skills and attitudes that all mental health clinicians should acquire within two years of commencing work in mental health services.

1. Rights, responsibilities, safety and privacy
2. Consumer and carer participation
3. Awareness of diversity
4. Mental health problems and mental disorders
5. Promotion and prevention
6. Early detection and intervention
7. Assessment, treatment, relapse prevention and support
8. Integration and support
9. Service planning, development and management
10. Documentation and information systems
11. Evaluation and research
12. Ethical practice and professional responsibilities.

www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs

Victoria's strategy for safety and quality in public mental health services

The *Victorian strategy for safety and quality in public mental health services 2004–2008* provides a framework and plan for developing a safe, high quality, public mental health system. Working and practising safely is a critical aspect of quality. When people are mentally unwell, they can respond unpredictably. Mental health service environments and clinicians need to be prepared to predict and respond appropriately to aggression, violence and risk. Responding to risk and maintaining workplace safety are shared responsibilities of services and clinicians.

All services are expected to have structures and activities in place to promote consumer and carer focused mental health care, the safety and quality of practice, and system improvement and accountability. Most services have a quality coordinator and processes that examine practice and service delivery to determine what is working well and what might be improved.

The *Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression in Victoria's mental health services 2004* provides further guidance in this area.

Chief Psychiatrist's guidelines and program management circulars

The Chief Psychiatrist and the Mental Health Branch issue clinical practice guidelines and program management circulars in various areas of practice. The guidelines and circulars intend to help staff understand their obligations and how best to proceed in specific areas. Most services have incorporated them in their local policies and procedures. The guidelines and circulars cover topics such as the understanding the *Mental Health Act 1986*, the management of illicit substance use in inpatient units, catchment areas and new service arrangements.

For a set of the Chief Psychiatrist's guidelines visit www.health.vic.gov.au/mentalhealth/cpg/index and for program management circulars visit www.health.vic.gov.au/mentalhealth/pmc/index

Discipline-specific standards

Clinical mental health services employ qualified professionals and support staff to deliver services. The largest groups are nurses (Division 1 and 3 registered nurses), enrolled nurses (Division 2 registered nurses), medical practitioners (some of whom are psychiatrists), psychologists having completed masters level training or above, social workers and occupational therapists (some with specialist training). Psychiatric service officers (PSO's) and personal care attendants (PCAs) also play an important role in providing care and support in some services.

Each profession has its own code of conduct and professional standards and these are important references for defining expectations of discipline-specific conduct and skills. Discipline seniors or supervisors have a key role in assisting staff to understand these expectations in practice.

1.4 Consumer and carer involvement in service delivery

Mental health services are required to involve consumers and carers in the governance, planning, development and evaluation of services. The potential benefits of consumer and carer participation include:

- a shared understanding between consumers, services and administrators about issues and what to expect from mental health services
- a service system that reflects changing community values and needs
- improved quality of care
- more responsive management practices and decision-making
- demystification of mental health services
- increased community confidence in services.

Some of the practical ways that services encourage consumer and carer participation in service planning and delivery include:

- support for consumer and carer advocates, including consultants as paid employees
- ensuring that consumers and carers know how they can provide feedback on services
- consumer and carer representation on boards or committees of management.

Consumer and Carer Consultants

The consumer and carer consultant programs provide an important means of improving service quality and responsiveness through the involvement of carers and consumers with direct experience of mental health services.

Consumer consultants

- Enable consumer perspectives to be included in all aspects of the mental health service's planning, delivery and evaluation.
- Assist in the improvement of the mental health service's responsiveness to consumer needs.
- Communicate the broad views of consumers to mental health services and other relevant services.

Detailed information on consumer consultants can be found at www.health.vic.gov.au/mentalhealth/pmc/cc.htm

Carer consultants

Adult mental health services can choose to employ a carer consultant using funds from the Mental Health Carer Support Program – Brokerage fund. Specific information on this initiative is at www.health.vic.gov.au/mentalhealth/pmc/mhcsp_carer.pdf

Carer consultants provide information and referral to families and carers. In working with mental health services, the carer consultant works collaboratively with mental health staff in developing service responsiveness to the needs of families and carers.

1.5 Key documents and resources

A number of documents are listed here and are relevant references at the time of publication. Over time additional or alternate documents may be found at the websites listed.

Commonwealth mental health policy

www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs

State mental health policy

www.health.gov.au/internet/wcms/Publishing.nsf/Content/Mental+Health+and+Wellbeing-1

Safety and quality

www.health.vic.gov.au/mentalhealth/quality

Chief Psychiatrist's guidelines and program management circulars

www.health.vic.gov.au/mentalhealth/cpg/index

www.health.vic.gov.au/mentalhealth/pmc/index

2 Mental health services in Victoria

This section provides an overview of the public clinical mental health system in Victoria, describing its targeting, organisation and component service types.

2.1 Who uses public clinical mental health services

Many public and private service providers deal with people with mental illness. These include providers in the primary care sector, such as general practitioners, counsellors, support agencies, non-government services and self-help groups.

Public clinical mental health services function like other secondary or tertiary medical services. A person is referred to or visits a specialist service for an opinion or when a primary health service cannot adequately meet their needs. Anyone can refer a person to a mental health service. The referring party may be any service provider, a friend, family member or consumers themselves, unlike other specialist services where referrals need to occur via a general practitioner. Mental health services manage each individual referral through their triage and intake processes.

Public clinical mental health services are aimed primarily at people with more severe forms of mental illness or disorder (psychotic and non-psychotic), whose level of disturbance or impairment prevents other services from adequately treating or managing them.

People move in and out of the service system depending on need. Contact may be short or the person may require specialist services for many years. Following discharge from the mental health service, the person may return to the care of their general practitioner, or treatment may no longer be needed. Some consumers have their needs met by a combination of public and private services, through **shared care** arrangements with general practitioners or private psychiatrists, community mental health services and other support services.

Important principles for specialist mental health service providers are to monitor and assess consumer need and, when appropriate, to pursue opportunities for discharging the consumer to other available community primary health or specialist services.

Public mental health services include both clinical and psychiatric disability rehabilitation and support services (PDRSS). The organisation and major components of these services are described below.

2.2 Area-based clinical services

Clinical mental health services are part of larger health services that deliver a range of hospital and community based services.

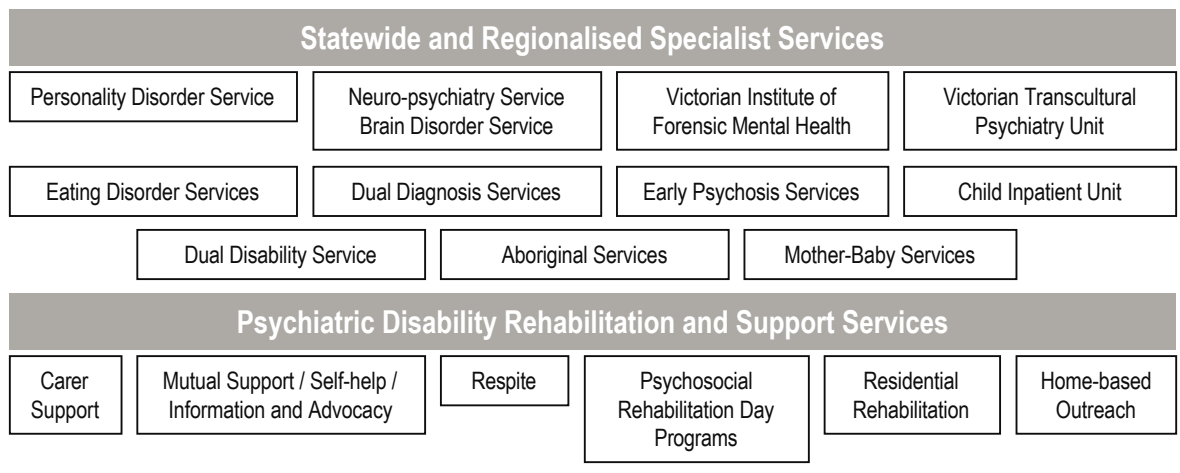
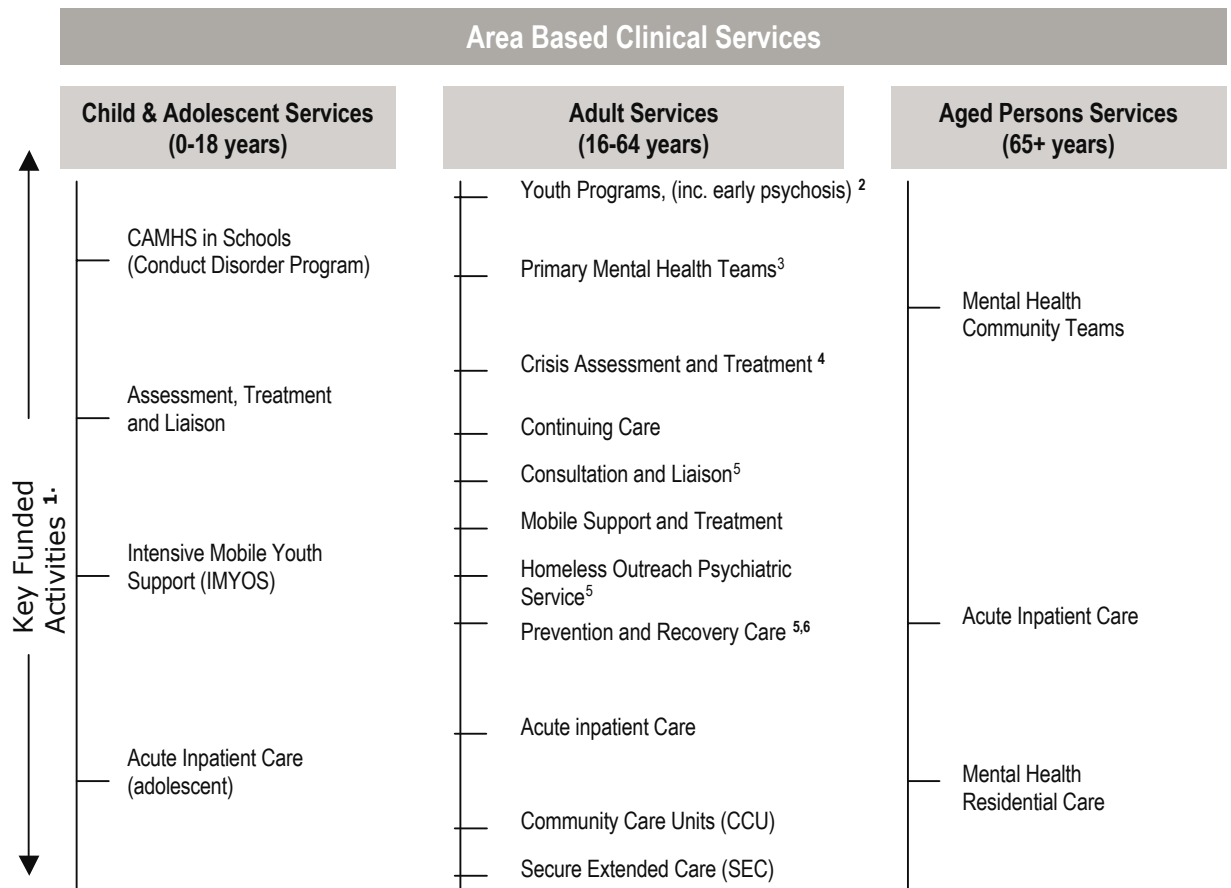
Three main program areas deliver clinical mental health services, reflecting the different needs of people across the lifespan. They are:

- child and adolescent (0–18 years)
- adult (16–64 years)
- aged persons (65 years or older).

These services are often called area mental health services (AMHS) because they are organised and delivered on an area basis within a geographically defined catchment area. The purpose of a catchment area is to ensure a service takes primary responsibility for providing mental health services to people who live in its area (area of origin) and to provide a mechanism for funding to services. The catchment area approach is different from the organisation of general medical services where people can typically present at a hospital or service of their choice. However, this difference does not preclude the delivery of service to a person who presents in an area other than the one where they reside, as a transfer would occur as necessary.

Victoria has 13 child and adolescent services, 21 adult area mental health services and 17 aged person services. Due to the number of catchment areas and the fact that they may occasionally alter, it is advisable to consult the 'accessing services' section of www.health.vic.gov.au/mentalhealth to accurately locate services by suburb. The website identifies the catchment areas for child and adolescent services, adult and aged person services and illustrates these via maps of metropolitan and rural Victoria.

Figure 2: Victoria's public mental health service system



1. Delivery of activities varies between area mental health services. Some services have separate teams for the various activities, others operate 'integrated teams' performing a number of different functions.
2. All child & adolescent and adult mental health services are expected to respond to the needs of youth, recognising the 15-24 year period as a key period for the development of mental illness.
3. Covers all ages (0 – 65+)
4. Responsible for all age groups after hours. In business hours CAMHS and APMHS perform this function for their target group.
5. Not available in all areas.
6. Delivered in conjunction with PDRSS

The three main aged-based clinical programs are described below. Note that while services are broadly structured around age groups, this primarily aids service planning and program development. The age criteria are not intended to exclude individuals whose needs may be better met by another program. For example, a physically robust 65-year-old may have his or her needs better met by remaining in the adult program. Alternatively, the aged persons mental health service may better meet the needs of a 65-year-old requiring ongoing mental health care displaying cognitive deterioration and multiple physical co-morbidities. A mature 16-year-old who is likely to require ongoing services may better be transferred to the adult program than continuing to be managed in the child and adolescent program.

The different program areas work together to provide continuity of care across their program boundaries. The older adolescent and young adult group is an example of where child and adolescent mental health services and adult mental health services share responsibility for delivering services. This age group has the highest rate of first onset of a mental disorder. Suicide rates are also high in this age group, and drug and alcohol use is increasingly complicating the assessment and treatment of many young people. Some services have chosen to establish a youth subprogram as a way of providing services to this age group, while early psychosis services – targeting young people with a first onset psychosis – are being developed on a regionalised basis.

Similarly, mental disorders later in life require close cooperation by adult services and aged persons services. Older people with increasing levels of dependence may require more practical age-related supports. People who have been receiving services from the adult program should not be automatically transferred to the aged person program when they reach age 65 unless the latter program would better meet their service needs.

Child and adolescent mental health services (0–18 years)

These services are for children and adolescents up to the age of 18 years who have serious emotional disturbance. The target group includes young people with a diagnosable **psychiatric disorder** whose condition is seriously detrimental to their growth or development and/or who have serious difficulties in their social group or family.

Some children and adolescents are at higher risk of a serious mental disturbance. They include:

- victims of physical, sexual and/or emotional abuse
- those within the welfare and juvenile justice system
- homeless youth
- those from severely disruptive homes
- those whose parents suffer from a mental illness or a dependence on drugs or alcohol
- those with developmental or learning difficulties and/or an intellectual disability
- those with chronic health problems and disabilities
- post-trauma and post-disaster victims.

Child and adolescent services also have sub-specialities, such as infancy and young children, and others that focus on the developmental tasks of adolescence and youth. Each has its own age-appropriate range of services and interventions. For example, young children may be brought for treatment by their parents or a service, whereas adolescents may be more reluctant to seek out support so services 'outreach' to them.

Many children and adolescents with emotional disturbance do not require specialist mental health services and are supported by primary care and other health, educational and support services. Specialist mental health services operate as part of this broader service network and must develop and maintain links with other services.

Adult mental health services (16–64 years)

Adult mental health services are aimed primarily at people with serious mental illness or mental disorder who have significant levels of disturbance and psychosocial disability due to their illness or disorder. Commonly, these people have a diagnosed major mental illness (such as schizophrenia or bipolar disorder), but the target group also includes some people with severe personality disorder or other conditions (such as severe anxiety disorder), and those who present in a situational crisis that may lead to self-harm or inappropriate behaviour towards others. The distinguishing factor is the level of severity of the disturbance, impairment and risk (acute or chronic).

The needs of people aged 16–64 years also differ across the lifespan, requiring services to be able to respond flexibly. For example, young adults need services that not only respond to their **symptoms** of illness or disturbance, but also help them continue their personal growth and development. Vocational and skills development, recreational activities and peer relations are all important aspects to be considered in their treatment and care.

Aged person mental health services (65 years+)

These services are primarily for people with a longstanding mental illness who have grown older, and those who have developed illnesses such as depression and psychoses in later life. They also provide treatment and care for people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

Older people who are mentally ill or who develop disorders in later life have an increasingly complex array of presentations as the effects of the ageing process become more prominent. Co-existing physical factors may complicate the detection of the underlying cause of their condition.

People whose mental illness is late onset or characteristic of older **patients** should be treated as far as possible as part of the aged care system, to enable linking with the broader network of health and community services and supports for older people.

Service components

As shown in Figure 2, each of the three clinical mental health programs—child and adolescent, adult and aged persons—has several components, covering a continuum of services from inpatient to community-based options. A comprehensive mental health service must encompass services for both acute episodes and long term care.

Each service component delivers a particular level and type of service to suit the consumer at a given point in time. Services aim to respond to the different needs of individuals and to changes in consumers' needs over time, so as to provide the right level of service at the right time.

Components are expected to work together to provide an integrated set of services, linking consumer assessment, treatment, rehabilitation and accommodation support services.

A consumer who is case managed by a continuing care clinician may need a crisis service or admission to hospital when acutely unwell. On discharge from hospital, he or she may need to spend some time in a prevention and recovery care service before returning home.

2.3 Statewide and regionalised clinical services

Figure 2 illustrates the statewide and regionalised specialist services that support and complement area-based clinical mental health programs.

A number of specialist statewide services have been established to focus on particular problems and disorders. These services are funded to develop and disseminate best practice and service models for working with consumers who have particular needs. They typically engage in direct care, consultation, education and training and research. For example, the personality disorder service provides direct inpatient and outpatient treatment to consumers, and professional education and training to AMHS staff.

There are also a number of services being developed for particular clients in a region spanning several area mental health services. An example of a regionalised service is the unique program targeting 15–24 year olds in the western and northwestern suburbs of Melbourne.

2.4 Psychiatric disability rehabilitation and support services

Victoria has the largest non-government mental health sector in Australia. Known as **psychiatric disability rehabilitation and support services (PDRSS)**, this sector plays a vital role in supporting consumers and carers throughout the recovery process and forms part of the broader Victorian specialist mental health service sector. PDRS services are commonly referred to as non-clinical services. Strong and effective working relationships between clinical and PDRS services are essential to the provision of quality treatment and care.

PDRS services are predominantly funded to provide services to the adult population (16–64 years). However, there are a number of limited programs offered to the aged population (65 years and over) in some catchment areas.

Local PDRSS have defined catchment areas, typically in line with the local AMHS. This may vary in some geographic areas.

Figure 2 shows key components of PDRS services.

2.5 Key documents and resources

Department of Health and Community Services Victoria, 1994, *Victoria's mental health service: the framework for service delivery*, Melbourne.

Department of Health and Community Services Victoria, 1994, *Psychiatric crisis assessment and treatment services: guidelines for service provision*, Melbourne.

Department of Health and Community Services Victoria, 1995, *Mobile support and treatment services: guidelines for service provision*, Melbourne.

Department of Health and Community Services Victoria, 1996, *Victoria's mental health service: the framework for service delivery: better outcomes through area mental health services*, Melbourne.

Department of Health and Community Services Victoria, 1996, *Victoria's mental health service: the framework for service delivery: aged persons services*, Melbourne. (reprint 1998)

Department of Health and Community Services Victoria, 1996, *Victoria's mental health service: the framework for service delivery: child and adolescent services*, Melbourne.

Department of Human Services Victoria, 1996, *General adult community mental health services: guidelines for service provision*, Melbourne.

www.health.vic.gov.au/mentalhealth

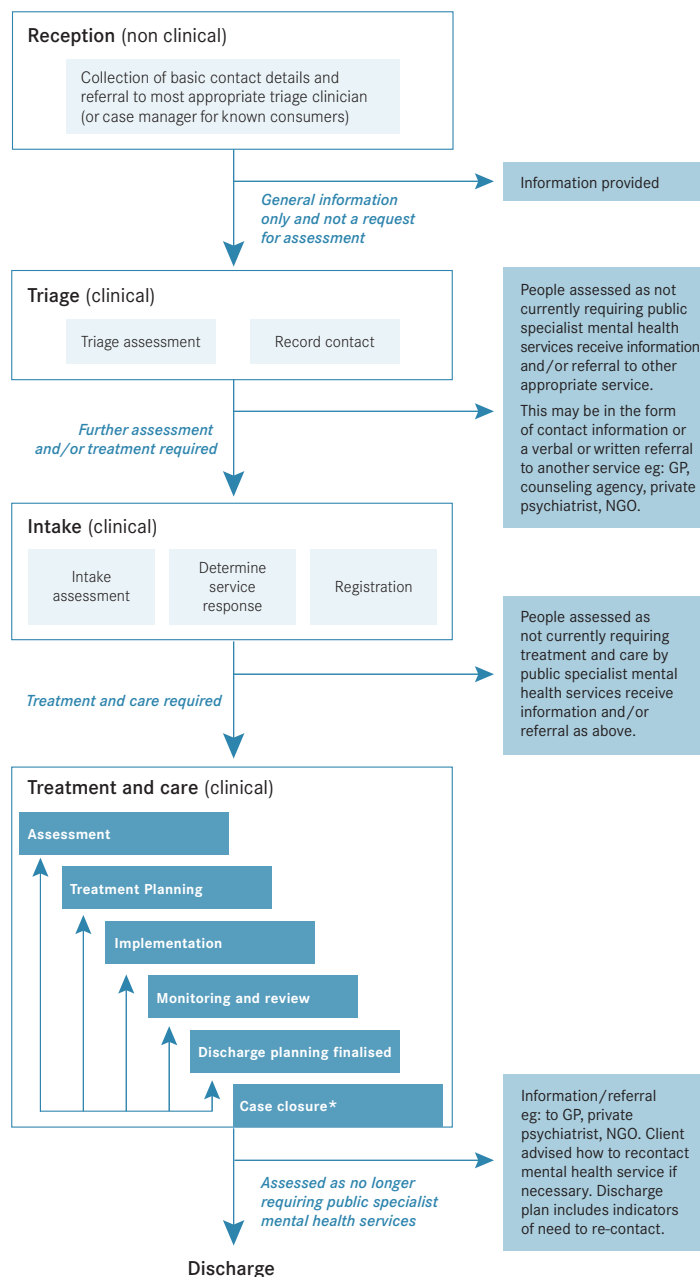
3 Clinical service delivery

This section focuses on the delivery of clinical mental health services. It describes key phases and functions of a typical pathway through the clinical service system, and goes on to discuss some of the philosophies and principles underpinning service delivery.

3.1 The service delivery pathway

A common approach to service delivery ensures consumers can expect to receive a similar type and range of services from service entry to discharge. Figure 3 depicts this pathway and charts the key functions typical of the different stages of service delivery.

Figure 3: The specialist clinical mental health service delivery pathway



* For some consumers, transitional treatment and care arrangements may apply (eg graduated discharge, shared care with other service providers)

Reception

First contact with a service is often with a receptionist. While receptionists may handle requests for general information, such as service locations, all requests for clinical information, assessment or service provision are transferred to a **triage** clinician. In some services clinicians answer all calls from the public as there is no reception.

Triage

Triage is what occurs when a potential consumer (or family member/service provider) contacts the mental health service. It is a clinical function and typically occurs over the telephone, although it can be conducted face-to-face when someone presents in person.

The role of the triage clinician is to conduct a preliminary assessment of whether a person has a mental illness or disorder, and to determine the nature and urgency of the response required.

Where it is considered that specialist mental health services are not the most appropriate option for the person, they may be referred to another organisation or given other advice.

Where triage indicates that specialist mental health services are required, a more detailed assessment is provided through the intake process. Although triage and intake assessment are conceptually two different functions, they can occur concurrently or be undertaken by the same clinician, particularly where the person presents in crisis and an immediate service response is needed.

Intake

The aim of intake is to obtain further information to assess the type and level of service response required. Intake is a clinical function and typically entails a face-to-face assessment, either in the person's own environment, at the mental health service, an emergency department, or in another setting.

Intake structures may differ between child and adolescent, adult, and aged services, and between metropolitan and rural services, due to service variations in team structure, composition and staff availability. For adult consumers in crisis, intake is generally the responsibility of the **crisis assessment and treatment (CAT) service**, particularly if the triage assessment indicates that the referred person may be acutely unwell. In many aged services one team may perform more than one clinical function (i.e. triage, intake, **treatment planning**).

Intake is considered the starting point of service delivery and it is the phase where consumers become registered on the statewide and hospital information systems. Data on consumers is essential for monitoring service activity and the overall demand on services. Personal details of the consumer are collected and a unique statewide unit record number is allocated for use by the service to record the delivery of its services.

Where a person is assessed as not requiring public mental health services, advice will usually be given or a referral made to another service. In these circumstances, the person will not be **registered** but will be counted as an 'unregistered client', so that the details of the contact can be accessed if the person presents again at a later stage. In these cases, intake may lead to referral to another agency that can more appropriately deal with the individual's needs.

Intake may also instigate a recommendation for an **involuntary treatment order**.

Comprehensive assessment

Assessment is a function performed at particular points in time. It is also continues throughout a consumer's contact with the mental health service.

At intake, the assessment involves:

- A comprehensive psychiatric assessment by one of the multidisciplinary team (including risk assessment and physical examination to identify any underlying causes for signs and symptoms)
- Additional **screening** measures and assessment processes if thought necessary.
- Further assessments by a medical practitioner or psychiatrist (including specialist physical examinations) are also completed as appropriate.

A consumer's mental health status is also regularly monitored using a standard suite of outcome measures that assist the consumer, carer and case manager to identify changes in the consumer's wellbeing over time.

If the person requires the service following triage and intake, a **case manager/coordinator** is appointed to manage treatment planning. That is, ensuring ongoing psychiatric assessment, organising any specialist assessments, conducting a 'needs for service' assessment and co-ordinating overall treatment and care.

Treatment/recovery planning

There is an explicit requirement under the *Mental Health Act 1986* that every consumer has a **treatment or recovery plan** (different services may refer to these plans in either of these ways), based on an assessment of his or her needs.

As highlighted above, the consumer's needs are assessed in a variety of psychosocial domains, some of which may only be able to be fully assessed when the acute phase of illness abates.

Treatment plans offer a mechanism for brief, active and regular communication about treatment between staff and consumers. The treatment plan is focused on recovery and provides direction for treatment and care in the immediate (a short term plan, a crisis or acute management plan) and/or longer term. For consumers in an inpatient setting, the plan is extended to guide staff in day-to-day treatment and care planning.

Treatment planning is consumer focused and clearly identifies the changes required to return the care of the consumer to less restrictive community based services. Family members and other carers providing ongoing care and support are actively involved in the planning process in keeping with the consumer's wishes.

Treatment/recovery plans are intended to complement the broader and more long-term objectives of other service plans, such as the **individual service plan (ISP)**. Consumers with community management via a case manager require an individual service plan. An individual service plan is expected to be comprehensive in its coverage of all psychosocial domains, and the full range of strategies to address them over time.

While the case manager is responsible for developing the ISP, others in the multi-disciplinary team may also initiate changes to the plan based on ongoing assessment or significant changes in the consumer's situation. The ISP identifies needs, priorities, strategies and parties responsible for implementing those strategies. The plan will depend on consumer need and includes the development of priorities that are workable and manageable for the consumer and the clinician.

Treatment, support and recovery implementation

A range of interventions is likely to be required as part of the treatment and recovery phase, of which case management is a key function. The case manager coordinates services, facilitates implementation of the treatment plan, and works with the consumer, carers and others in providing integrated service responses, including pharmacological treatments, psychological and other therapies and **psychosocial rehabilitation** (practical support, accommodation). Some of these interventions are provided by the mental health service, while others are provided by community agencies such as PDRS services. All interventions aim to enable recovery or maximise individual functioning and independence. Interventions are also individually tailored and responsive to the consumer's fluctuating and changing needs.

Monitoring and case review

Monitoring the consumer's progress and needs is a continual process. It includes evaluating the consumer's response to treatment and their progress against their planned objectives. Outcome measures are collected at key points in the treatment cycle (intake, review and discharge) to provide an overview of a consumer's progress and assist decision-making.

The multidisciplinary team formally reviews each consumer's progress at least every six months. These reviews offer the opportunity to identify new or emerging needs, and to assess the effectiveness of current strategies. The input of the multidisciplinary team is an important element in bringing different perspectives and collective wisdom to the consumer's treatment and care.

Discharge planning and case closure

Most people who experience mental illness do not need public mental health services for their entire lifetime. However, continuity of care is important and relapse prevention key to minimising the impact of any re-emergence of illness.

Discharge planning should commence from the earliest phase of service delivery, so treatment and care remain directed to this objective. A primary reason for monitoring the consumer's progress and outcomes is to facilitate timely discharge from the specialist clinical mental health service. Discharge planning, even when a consumer moves from one element to another within a service (e.g. from inpatient to community living), is important to ensure the consumer is supported at points of transition.

Typically, discharge from the mental health service is to the care of another service provider. General practitioners have a key role to play in discharge planning because of their capacity to provide ongoing treatment, monitoring recovery and relapse prevention. Discharge plans clearly nominate the consumer's GP to be involved and incorporate follow-up procedures for the GP and others to ensure that the person has been engaged successfully. Appropriate discharge planning will include strategies for the consumer's re-entry to the specialist mental health service where required.

A case is closed when the person no longer needs treatment, or when their clinical needs can be met by services other than specialist clinical mental health services, and effective referral has been completed.

A person may be involved with PDRS services following their discharge from the clinical service.

3.2 Key elements of service delivery

As discussed in Section 1 of this document, there are a number of policy and practice frameworks guiding the delivery of mental health services in Victoria. Some of the key themes and elements of these frameworks are discussed below.

Consumer centred care

Consumer centred treatment and care means keeping the consumer's needs at the centre of practice. This approach is based on a philosophy of service delivery that involves a partnership between those using and those providing services. The principle of consumer centred care is evidenced in practice when consumers are involved in their treatment plan, discuss treatment options, promote consumer choice and preference, and consumers and clinicians/services work together to achieve goals.

'... to create effective change, service providers need to move beyond seeking feedback to engaging with consumers through inquiring with consumers, planning with consumers, acting with consumers and evaluating with consumers.'

(M. Draper, 1997, in *Consumer focus collective 2001*, Literature Review)

A partnership between the consumer and carer is a requirement for a therapeutic relationship in mental health. Involving a consumer in the planning and review of their care in meaningful and respectful ways improves their engagement in the treatment process. This engagement encourages the consumer to remain in treatment and increases satisfaction with the services, which is known to be associated with better outcomes. Involving consumers in other aspects of service delivery, such as service planning and quality monitoring, is further recognition of the valuable personal perspective that consumers bring.

Partnerships with families and carers

A carer-focused approach recognises and supports carers in their key role of providing ongoing care and support to consumers. Families and carers often play important roles in the lives of people of all ages with a mental illness. With the move to community-based mental health care, carers have played an increasing part in providing care and support. To perform their caring role, carers need access to information and may also have support needs of their own. It is important to recognise that children sometimes assume a caring role for a parent with a mental illness. Involving families in the treatment and care process is at the heart of family-sensitive practice.

Partnerships with other services and sectors, and the broader community

Public clinical mental health services form only part of a broad range of responses for people with mental illness. To bring together the most appropriate range of services for individual consumers, clinicians and services need to develop cooperative relationships with service providers outside

the clinical mental health sector. Strong relationships with the PDRSS sector, GPs and private psychiatrists are particularly important. Other relevant services may include drug and alcohol, child and family, accommodation, education, employment, home and community care and aged care.

Continuity of mental health care

Continuity of care is another aspect of ensuring consumers can access the most appropriate services when they need them. It means making every effort to ensure consumers can move between mental health service components as their needs change with the least disruption. It requires services for the consumer to be coordinated across service settings, whether hospital or community based, and across different types of services. This coordination is a key task of case management.

Co-ordinated care through case management

Co-ordinated care through case management is a core feature of service delivery in public mental health services. It is the primary method for achieving continuity of care, and is a linchpin for providing services to the individual consumer in a timely and effective way.

The function of case management recognises that people with a mental illness or disorder characteristically have diverse needs that may require a broad range of services. The case manager's/coordinator's primary responsibilities include facilitating assessment, service provision and coordinating services across time and settings. Similarly, the role of carers in the consumers' life and carer provision of, and capacity to provide ongoing care to the consumer needs to be assessed and appropriate supports put in place.

Key roles of a mental health case manager/coordinator are to:

- Assess, plan and individualise treatment and care in collaboration with the consumer, carers and relevant others
- Coordinate services for the consumer in a timely and efficient manner
- Be a point of contact and accountability
- Guide the consumer and carers through the system
- Provide intensive support and intervention
- Monitor and review the intensity of case management need
- Access multidisciplinary input as needed
- Link the consumer and carers to other community supports and agencies
- Ensure effective discharge planning

A multidisciplinary approach

Treatment and care in mental health are based on a multidisciplinary team approach. Teams normally include mental health nurses/registered nurses, social workers, clinical psychologists, occupational therapists, psychiatric registrars/medical officers and consultant psychiatrists. Multidisciplinary input is designed to ensure consumers in mental health services have access to the full range of skills and techniques needed to treat their illness.

Clinical accountability

A clinical director is responsible overall for the clinical leadership of an area mental health service.

The **authorised psychiatrist** has specific powers, duties and functions under the *Mental Health Act 1986* and is able to delegate all of these functions (with the exception of the power of delegation and duties in relation to the Forensic Leave Panel) to any other psychiatrist employed by the mental health service. Delegated functions include responsibility for assessment and treatment, and other decisions regarding the type and level of service provided to consumers and their carers. Delegates then act with all the powers of the authorised psychiatrist.

Individual clinicians are expected to uphold high levels of clinical accountability. All professionals involved in treatment are responsible for their actions and decisions in dealing with consumers and their carers. Supervisors are legally accountable for ensuring proper supervision.

Clinical staff are accountable to discipline seniors for practice that is consistent with the level of their experience. Staff are also accountable to team leaders for work within the team and for meeting agreed expectations.

Most importantly, staff are accountable to the consumers and carers with whom they work, to provide them with the best possible service.

A recovery orientation

Hope of recovery and optimism about the future are important factors that aid recovery from illness. A recovery focus within all service types and programs, as embodied in practice and attitudes, is essential to promoting hope, wellbeing and a sense of self-determination for people with mental illness. A recovery orientation allows for and creates new meaning and purpose, and encourages consumers to pursue personal goals and interests.

In the context of mental illness and mental health, recovery is understood as a deeply personal, unique process of moving towards a satisfying and meaningful life after experiencing a mental illness. Recovery is viewed as both a process and an outcome towards which all those involved in the consumer's treatment, care and support can work.

A recovery orientation is a practical and positive way of challenging myths about the inevitable and enduring course of mental illness and helps to reduce stigma and marginalisation of people with mental illness.

Culturally sensitive practice

The cultural background of consumers significantly influences the way mental illness and treatment is understood, and the nature and timing of help-seeking for mental health problems.

Culture is a broad concept reflected as a set of practices, traditions, behaviour and values that distinguish one group of people from another. Culture includes but is broader than just ethnicity. Cultural differences or qualities may be influenced by ethnicity, country of origin, sexual orientation, religion, age or gender.

Ignorance of the way culture influences actions and behaviour can lead to poor quality psychiatric assessment, inaccurate diagnosis and inappropriate treatment and care. Commonwealth and State mental health policies identify the importance of culturally sensitive service planning and practice to meet the needs of those from culturally and linguistically diverse backgrounds. This requirement is further embodied in the National Practice standards for the mental health workforce, *National standards for mental health services* and the Victorian *Mental Health Act 1986*.

Early intervention and relapse prevention

A growing body of evidence is showing that the impact of mental illness can be reduced and outcomes improved if problems are identified and treated early. Minimising the disability and impairment associated with illness is critical in hastening recovery. Strategies to enhance early intervention include:

- working with community services and primary care services to identify effective treatment of mental health problems at an early stage of life or early in the pathway of disorders
- working with consumers and carers to identify relapse patterns (early warning signs)
- skill-building and education to strengthen a consumer's resistance to stress and relapse.

Monitoring and reporting

Mental health services require systems for monitoring and evaluating their quality and effectiveness against the *National standards for mental health services*. This performance monitoring and evaluating occurs in a number of ways.

All mental health services are required to meet certain performance targets as part of their service agreements with the Department of Human Services. Indicators of performance include the number of new consumers, the numbers of admissions and discharges, the average length of stay in an inpatient unit, the number of community contacts, and the timeliness of data reporting. These are measures of a service's activity level and allow for comparison with the performance of similar services across the State.

Services also monitor their performance for other reporting requirements. Clinicians are required to keep certain statistics to help the service meet its obligations. A system-wide database for collecting patient information, known as RAPID (Redevelopment of Acute and Psychiatric Information Directions), operates across Victoria's mental health service system. Data is entered via the Client Management Interface (CMI).

Every person who becomes a registered consumer of a public mental health service is given a unique statewide identifier. Strict levels of confidentiality and privacy apply to the use of this system, and clinicians need to be thoroughly familiar with and abide by these.

Outcome measurement

Outcome measurement is another mechanism for improving service quality for individual consumers and the service as a whole. Outcome measures are questionnaires used with consumers to assess their mental health and wellbeing at different points of time during contact with mental health services. They are commonly used at the beginning and end of an episode of treatment, and at each review of an individual service plan. Nationally agreed suites of measures apply to each services age group.

Outcome measures help clinicians identify what has improved for a consumer, and areas that require further treatment and support. Clinicians complete most of the measures, but there is a consumer self-rating measure in the suite for each age group. These measures can help highlight changes in an individual consumer over time, and they can also be used at a broader level to reflect on the effectiveness of clinical practice.

More information on this can be found at www.health.vic.gov.au/mentalhealth/outcomes/index

3.3 Key documents and resources

Department of Health and Community Services Victoria, 1995, *Victoria's mental health service: improved access through coordinated client care*, Melbourne.

Department of Health and Community Services Victoria, 1997, *Tailoring services to meet the needs of women*, Melbourne.

Department of Health and Community Services Victoria, 1995, *Working with consumers: guidelines for consumer participation in mental health services*, Melbourne.

Department of Health and Community Services Victoria, 1996, *Improving services for people from a non-English speaking background*, Melbourne.

www.health.vic.gov.au/mentalhealth/publications/pubs.htm

4 Mental health legislation

A number of laws apply to mental health services. Wherever they work in the system clinicians need to know about the *Mental Health Act 1986* and the Mental Health Regulations 1998, which are the principal laws governing public mental health services in Victoria.

Sound knowledge of the principles and relevant sections of the legislation is essential to mental health staff. While clinicians are not expected to be lawyers, they do need to know what powers and responsibilities they do and do not have, the legal principles that should guide their clinical decisions, and what rights consumers have.

4.1 The legislative framework

The *Mental Health Act 1986* is the principal law governing mental health services in Victoria. The Mental Health Regulations 1998 prescribe matters that give effect to the Act, such as forms, fees and statements of patient's rights. Current copies of the Act and the Regulations should be available in work areas for clinicians to read. Copies of the Act and the Regulations can be viewed or downloaded from the Victorian Legislation and Parliamentary Documents website at www.dms.dpc.vic.gov.au

In addition to the *Mental Health Act* and the Mental Health Regulations, other relevant legislation may include:

- *Aged Care Act 1997* (Commonwealth)
- *Health Records Act 2001*
- *Freedom of Information Act 1982*
- *Children and Young Persons Act 1989*
- *Guardianship and Administration Act 1986*
- *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*
- *Sentencing Act 1991*
- *Coroners Act 1985*
- *Information Privacy Act 2000*
- *Drugs Poisons and Controlled Substances Act 1981*
- *Occupational Health and Safety Act 1985*

4.2 Mental Health Act 1986

Each state has its own mental health legislation. The jurisdiction of the Victorian *Mental Health Act* does not extend beyond the borders of this state, except in relation to special cross border provisions.

Some areas of the Act are broadly referred to in this document. Further information can be found at www.health.vic.gov.au/mentalhealth/

The Act defines the rules and safeguards that apply when treatment and care are provided to people with mental illness, especially involuntary patients. It applies to all employees of **approved mental health services** and specified other **psychiatric services**.

An approved mental health service is a service that is proclaimed or 'gazetted', which enables it to treat involuntary patients. Typically, public hospitals that have an acute psychiatric inpatient unit are proclaimed to be approved mental health services. Every approved mental health service has an **authorised psychiatrist** who is appointed by the board of the health service. The authorised psychiatrist is a qualified psychiatrist who has specific functions under the Act, including the power to consent to treatment on behalf of an **involuntary patient**.

The Act governs the treatment and care of involuntary patients and some aspects of the treatment and care of **informal patients (voluntary)**. Informal patients, referred to as '**persons**' under the Act, admit themselves to hospital or consent to treatment in the same way as anyone else seeking any other form of medical treatment. Involuntary patients, referred to as '**patients**' under the Act, are people whose mental illness means they refuse or are unable to consent to treatment and who are considered to require treatment.

The Victorian Act places strong emphasis on:

- patient's rights
- treatment in the **least restrictive environment** consistent with the effective provision of treatment and care
- involuntary status having to be associated with treatment and care

The Act is organised in parts covering particular procedures, practices and functions.

Intention of the Act

Understanding the intention (the objects) of an Act helps clinicians to interpret it. The *Mental Health Act's* objects are to:

- provide for the care, treatment and protection of mentally ill people who do not or cannot consent to that care, treatment or protection
- facilitate the provision of treatment and care to people with a mental disorder
- protect the rights of people with a mental disorder
- establish the Mental Health Review Board, the Psychosurgery Review Board and the Victorian Institute of Forensic Mental Health, and provide for the appointment and functions of community visitors
- ensure people with a mental disorder are informed about the Act and make use of its provisions.

The Act is to be interpreted so:

- people with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and the least possible intrusive manner consistent with the giving of effective giving of care and treatment.
- in providing for the care and treatment of people with a mental disorder and the protection of the public, any restriction upon the liberty of patients and other people with a mental disorder and any interference with their rights, privacy, dignity and self-respect are kept to the minimum necessary in the circumstances.

Principles of treatment and care

The Act sets down principles designed to ensure high quality treatment and care that best meet the needs of the person with a mental disorder, and which involve the person in decisions about their treatment. These principles are intended to guide clinicians' day-to-day decisions and ensure services reflect good practice principles.

Principles of treatment and care in the *Mental Health Act* are:

- People should be provided with timely and high quality treatment and care in accordance with professionally accepted standards.
- Wherever possible, people should be treated in the community.
- Treatment and care should be designed to assist people to, wherever possible, live, work and participate in the community.
- Treatment and care should promote and assist self-reliance.
- People should be provided with appropriate and comprehensive information about their mental disorder, proposed and alternative treatments, including medication, and services available to meet their needs.
- People should be treated near their homes or the homes of relatives or friends wherever possible.
- When receiving treatment and care the age, gender, religious, cultural, language and other special needs of people should be taken into consideration.
- The prescription of medication should meet the best health needs of the person and be given only for therapeutic or diagnostic purposes and never as a punishment or for the convenience of others.
- Appropriately qualified people within a multidisciplinary framework should provide treatment and care.
- Every effort that is reasonably practicable should be made to involve a person in the development of an ongoing treatment plan, and treatment and care should be based on this plan. The plan should be reviewed regularly and revised as necessary.

Patients' rights

People with a mental illness are entitled to the same rights as any member of the community. However, when a person has a mental illness, those rights might sometimes be curtailed by the need to provide the person with effective treatment. This will always be done in accordance with the involuntary treatment provisions of the Act. The Act includes a number of safeguards to ensure any intrusion on a person's rights is the minimum necessary in the circumstances.

The Act requires patients to be given a specific **statement of rights** (printed as a patient rights booklet) advising them of their legal rights under the Act, including the right to obtain legal representation and to have a second psychiatric opinion. The patient must also be given a verbal explanation of the information in the statement and, if they do not appear to understand it, arrangements must be made to convey the information in the language, mode of communication, or terms that they are most likely to understand.

Clinicians in mental health services are required to make decisions that balance a person's treatment needs, their wishes and rights to self-determination, and community and professional expectations about acceptable practice and risk.

Initiating involuntary treatment

Mental illness on its own is not sufficient reason to interfere with a person's liberty. For a person to receive involuntary treatment, the five involuntary treatment criteria in the Act must apply to the person.

Criteria for Involuntary Treatment

Section 8(1) Mental Health Act 1986

- (a) the person appears to be mentally ill (*a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory*); and
- (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
- (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
- (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
- (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

More detailed information on the criteria and the procedures to be followed can be found at www.health.vic.gov.au/mentalhealth/mh-act/flowchart.pdf. In addition, services have information readily available in the form of local guidelines or procedures, and senior staff can assist clinicians.

Community Treatment Orders

Community Treatment Orders (CTO) enable involuntary treatment in the community and are a less restrictive option than inpatient treatment. A CTO is preferred if a person requires involuntary treatment, but is thought not to need the level of supervision and treatment of a hospital, and can be safely and effectively treated in the community.

A CTO carries a mutual obligation on the person to comply with the CTO and their treatment plan, and on the service to provide treatment and support consistent with the order and the plan. Case managers have an important role in assisting the person on an order to understand and meet its requirements and the treatment plan. There is an implicit goal to work toward a consumer coming off the order.

The authorised psychiatrist (or their delegate) who has been nominated as the **monitoring psychiatrist** on the person's treatment plan is the primary decision-maker regarding a person being placed on a CTO, being kept on it or discharged from it.

The Chief Psychiatrist's guideline, *Community treatment orders*, provides a comprehensive guide to working with people on CTOs. It can be found at www.health.vic.gov.au/mentalhealth/cpg/index.htm

Consent

Capacity or willingness to consent to psychiatric treatment lies at the heart of the *Mental Health Act*. If a person requires psychiatric treatment and the person has refused or is unable to consent to that treatment, involuntary treatment should be considered.

In considering whether a person has refused or is unable to provide consent (including informed consent) to treatment, only the person's personal refusal or consent is relevant. Family members, carers or guardians cannot consent to psychiatric treatment, except in some instances in which parents may consent on behalf of young children.

If a person has been made an involuntary patient, the authorised psychiatrist may consent to necessary emergency medical and psychiatric treatment on the person's behalf.

Involuntary status must not be taken as incompetence for decision making in all areas. An involuntary patient may be willing and able to make decisions relating to other areas of their life, for example where to live, the need for general medical treatment, or how to use their finances. Likewise, the inability to consent at one point of a person's illness does not mean the person cannot consent later when they are more able to fully consider the issues. It is important to work with the person to educate and build their capacity to consent to decisions that affect them.

The *Mental Health Act* also sets out the consent requirements for involuntary patients in relation to **non-psychiatric treatment**. If an involuntary patient is unable to provide informed consent to non-psychiatric treatment, the Act sets out a process and lists the categories of people able to give substitute consent on behalf of the patient.

Note that the *Guardianship and Administration Act 1986* governs consent to special procedures, being procedures that are reasonably likely to render the patient permanently infertile, termination of pregnancy, removal of tissue for transplantation purposes, and procedures carried out for the purpose of medical research (including psychiatric research).

Confidentiality

Confidentiality between a consumer and clinician is fundamental to the therapeutic relationship and part of all professional codes of conduct. Clinicians are obliged to keep identifying information confidential unless the person consents to the disclosure of that information to another person or service, or where there are specific grounds under the *Mental Health Act* for disclosure without the person's consent.

The *Mental Health Act* details a clinician's obligation to keep information confidential, and it lists general and specific circumstances in which information may be disclosed with and without consumer consent. Disclosure means giving information to an individual or organisation *external* to your mental health service. Clinicians *within* a service may share and use clinical information if it is required in connection with the consumer's further treatment.

A useful distinction in deciding which law applies is to remember that the:

- *Mental Health Act 1986* is the principal law regulating the disclosure of health information by specialist mental health services
- *Health Records Act 2001* is the principal law regulating the collection and use of health information by mental health services.

Consent is the starting point when considering disclosure. Part of clinical work is helping a consumer understand the benefits or reasons for sharing information in a particular circumstance. This understanding helps the person to decide what they may be willing to disclose and to whom.

Disclosing any information should always follow the 'need to know' principle. Relevant factors include:

- the purpose of the disclosure
- whether it can be met in any way other than revealing consumer-specific information
- whether the requester is entitled to receive information under the Act
- the minimum amount of information that needs to be disclosed to achieve the purpose.

The law recognises specific circumstances in which information may need to be disclosed without the consent of the person, including:

- communicating with families, carers and/or guardians who are actively involved in providing ongoing care and support to a mentally ill person, if the information is reasonably required for the ongoing care
- disclosing information to other service providers (such as general practitioners or other specialist mental health services) engaged in providing further treatment to the person.
- disclosure to lessen or prevent a real serious and imminent threat to the life, health, safety or welfare of a consumer or any other person.

The decision to disclose information is a clinical judgement based on what the law permits, and what is in the best interests of the consumer. New clinicians may find the questions of whether and what to disclose to be complex. Any uncertainties about confidentiality requirements should be discussed with a more experienced clinician.

The role of the Chief Psychiatrist and statutory practices

The **Chief Psychiatrist** is a statutory position under the *Mental Health Act* that is responsible for the medical care and welfare of persons receiving treatment or care for a mental illness. The position has broad ranging powers of investigation and responsibility for a range of activities relating to the monitoring of standards of treatment and care. The Chief Psychiatrist is an avenue of complaint and appeal for consumers, carers and others in relation to consumers' treatment and care or contact with mental health services.

The *Mental Health Act* recognises that certain intrusive and restrictive practices have a legitimate and necessary place in mental health services, but allows them to be performed only under strict regulation. These practices are often referred to as 'statutory practices' and include seclusion, mechanical **restraint** and electroconvulsive therapy. Services must send a monthly report on the occurrence of these practices to the Chief Psychiatrist.

The *Mental Health Act* requires an annual examination of a patient's mental and general health be performed and reported to the Chief Psychiatrist. The death of any person receiving treatment or care from specialist clinical mental health services that is a 'reportable death' must be reported to the Chief Psychiatrist and to the Coroner.

Review mechanisms

The protection of consumer rights requires mechanisms for external review of patients' involuntary status. The **Mental Health Review Board** is established under the *Mental Health Act* as an independent body to automatically review orders made for all involuntary patients. Involuntary patients must be reviewed within eight weeks of being placed on an involuntary treatment order and, thereafter, at least every 12 months. A patient may also appeal to the Board against their involuntary treatment order at any time. The board will either confirm the order or discharge the patient from involuntary status.

The board also reviews decisions to extend a Community Treatment Order (CTO). The Board can direct the authorised psychiatrist to make a CTO for an involuntary inpatient.

The *Mental Health Act* provides that patients have a right to view their clinical file before a board hearing. Clinical staff have a key role in presenting clinical information to the board and assisting and supporting consumers to appear and present their case.

The *Mental Health Act* also provides for **community visitors** to visit mental health services to inspect the therapeutic amenities, talk with consumers, take up their concerns with service management, and generally advocate on their behalf. Community visitors may inquire into the general care and welfare of people receiving treatment and care, and whether treatment and care are being delivered consistent with the principles of the *Mental Health Act*.

4.3 Key documents and resources

Mental Health Branch website at www.health.vic.gov.au/mentalhealth

Chief Psychiatrist's clinical guidelines at www.health.vic.gov.au/mentalhealth

Department of Human Services privacy website www.dhs.vic.gov.au/privacy

Mental Health Review Board at www.mhrb.vic.gov.au

Community Visitors at www.publicadvocate.vic.gov.au

Mental Health Legal Centre at www.communitylaw.org.au/mentalhealth/

5 Glossary

Words or phrases shown in italics are defined elsewhere in the glossary.

Adolescent mental health services

See: *Child and adolescent mental health services (CAMHS)*

Adult mental health services

The network of public specialist mental health services providing assessment, treatment and support for people with serious mental illness who are aged 16–65 years of age. Services include community mental health centres, crisis assessment and treatment services, mobile support and treatment services, psychiatric inpatient services and non-government psychiatric disability rehabilitation and support services (PDRSS).

Approved mental health service

Publicly funded mental health hospitals able to admit or provide services to involuntary and security patients as well as voluntary patients.

Aged persons mental health teams

Specialist community mental health services that provide assessment, treatment, and support for people aged 65 and over who have a mental illness.

Area mental health services (AMHS)

The network of public specialist mental health services that operates in defined geographical areas.

Assessment

See: *Psychiatric assessment*

Authorised psychiatrist

The authorised psychiatrist has specific powers and duties under the *Mental Health Act 1986*. The authorised psychiatrist may delegate these powers and duties to other consultant psychiatrists in the area mental health services.

Carer

A person who has a caring and support role in the life of a consumer and whose life is affected by the consumer's welfare.

Case management/co-ordination

Case management is a core clinical function that aims to ensure the consumer receives the best possible treatment and support through the identification of their needs, planning individual goals and strategies and linking to appropriate services.

See: *Individual Service Plan, case managers, continuity of care*

Case manager/coordinator

A mental health professional employed by a community mental health service who has the primary responsibility for case management of a particular consumer. The consumer's case manager may be a social worker, psychiatric nurse, consultant psychiatrist, occupational therapist, medical officer or psychologist.

CAT service

See: *Crisis assessment and treatment (CAT) service*

Chief psychiatrist

The Chief Psychiatrist is a psychiatrist appointed by the Secretary, Department of Human Services, with overall responsibility for the medical care and welfare of persons receiving treatment for a mental illness within the state of Victoria.

Child and adolescent mental health services (CAMHS)

Specialist public mental health assessment and treatment services provided for children and adolescents up to eighteen years of age. Services include community based multidisciplinary services and psychiatric inpatient services.

Consumer

Consistent with prevailing views, the term consumer generally refers to the users of public mental health services. Organisations that represent users of mental health services have embraced the term 'consumer' because they feel that it acknowledges people with mental illness as individuals with legitimate rights, preferences and responsibilities. It covers children, young people, adults and older people.

Community treatment order (CTO)

Community Treatment Orders are made under the *Mental Health Act 1986*. They enable involuntary patients to receive treatment for their mental illness in the community. CTO's are made by an Authorised Psychiatrist and are less restrictive than involuntary inpatient treatment.

Comprehensive mental health service

People with a serious mental illness often have complex medical, psychological and social needs. A comprehensive mental health service is one that provides a range of services to meet the consumer's treatment and care needs, including community based services and inpatient care.

See: *Continuity of care, Individual Service Plan*

Consultant psychiatrist

Medical practitioners who have undertaken specialised training and registration qualifying them to diagnose and treat mental illnesses. Some have undergone further training to specialise in areas such as child and adolescent psychiatry, the psychiatry of old age or forensic psychiatry. Psychiatrists may work in psychiatric inpatient services, community mental health services or in private practice.

Continuity of care

Provision of mental health services to a consumer in a way that ensures care is continued when there is a change of service or case manager. An example is when a person leaves a psychiatric inpatient service and their care is transferred to the community mental health centre or where the consumer moves to a new area.

Crisis

See: *Psychiatric crisis*

Crisis assessment and treatment (CAT) service

A component of an Adult Area Mental Health Service which is available 24 hours a day to provide community based assessment and treatment for people experiencing psychiatric crisis. CAT services aim to prevent unnecessary hospitalisation, by providing treatment in the person's own environment such as in their home but may also work within emergency departments of hospitals. CAT services provide urgent assessment and will arrange inpatient admission if this is the most suitable treatment option.

Deinstitutionalisation

Describes the change from an institutional model of care in isolated stand-alone psychiatric hospitals to a system in which psychiatric treatment is provided by community mental health services in the consumer's own community and psychiatric inpatient units in general hospitals. This process has occurred gradually over the last 30 years.

Disability

See: *Psychiatric disability*

Diagnosis

A medical term meaning the identification of symptoms that are consistent with a particular illness or disorder. Sometimes a medical examination or tests can prove that physical illness is present. In mental illness, diagnosis is often more difficult and is based on observing and interviewing the consumer.

Dual diagnosis

The occurrence of a serious mental illness and a substance abuse disorder concurrently in the same individual.

Dual disability

The occurrence of a serious mental illness and an intellectual disability at the same time in the same individual.

Duty worker

A mental health professional at a community mental health service who is the first contact for people requesting services within an area mental health service. The duty worker undertakes an initial screening and may then arrange an intake assessment of the consumer's current problems and guide the consumer to other community services. The term 'triage' may be used instead of 'duty'.

See: *Triage*

Hospital order

An order made under the *Sentencing Act 1991*. It is used to order a person with a mental illness and who has been found guilty of a criminal offence to be admitted to and held in an approved mental health service for assessment and treatment rather than being sentenced to jail. A person on a hospital order may be placed on a restricted community treatment order (RCTO) as an alternative to inpatient treatment in an approved mental health service.

Hospital security order (HSO)

An order made under the *Sentencing Act 1991*. A court might make a HSO when a person with a mental illness has been found guilty of a criminal offence. By way of a sentence, the person is admitted to and detained in an approved mental health service for treatment rather than being sent to jail. The HSO is for a fixed time, in the same way as a sentence. If the person no longer meets the criteria for a HSO, they will be discharged from the approved mental health service and sent to prison to finish the rest of their sentence.

Individual service plan (ISP)

A plan based on a comprehensive assessment, outlining the consumer's goals and strategies for recovery. It covers the mental health services and general community services that the consumer requires. The plan is developed and reviewed regularly by the case manager, the consumer and with the consumer's permission, the family or carer and other key workers.

Informed consent

The consumer gives free and voluntary consent after having been given a clear explanation about the treatment/procedure, the benefits, discomforts and risks involved, the consequences of withholding permission, and alternative treatments.

Inpatient admission

A voluntary or involuntary hospital admission for the treatment and management of a person who has a serious mental illness.

Inpatient service

See: *Psychiatric inpatient service*

Intake assessment

The process that occurs when a person first becomes a consumer of a mental health service. The person will have an initial psychiatric assessment in order to determine the nature of their psychiatric problem, their treatment needs and the most appropriate service required and are registered as consumer of the relevant specialist clinical mental health service.

Integration of services

Coordination and linkage between services to ensure consumers receive continuity of care.

Intellectual disability

People with intellectual disability have learning difficulties and develop at a slower rate than normal. The condition is usually identified at birth or in early childhood. Intellectual disability is not a mental illness and requires very different specialist skills than those offered by mental health services. However people with intellectual disabilities can also suffer from a mental illness.

Intervention

A planned action taken by a mental health worker in the context of treatment e.g. counselling, intensive support, referral, or prescribing medication.

Involuntary admission

Admission to an approved mental health service for the treatment of a serious mental illness without the person's consent. All the involuntary treatment criteria in the *Mental Health Act 1986* must apply to the person and the procedures for commencing involuntary treatment must be met.

Involuntary patient

Describes a person receiving involuntary treatment under the *Mental Health Act 1986*. Treatment can be provided in either a community or inpatient setting.

See: *involuntary treatment order*

Involuntary treatment order (ITO)

An ITO is an order made under the *Mental Health Act 1986* that requires a person to receive involuntary treatment. Treatment can be provided in either a community or inpatient setting

Least restrictive environment/setting

This principle recognises that all consumers of public mental health services should be treated in an environment and manner that respects their individual worth, dignity, privacy and enhances their personal autonomy.

The *Mental Health Act 1986* requires that any restrictions on the liberty of people with a serious mental illness must be the minimum necessary to enable effective treatment to occur, and to ensure protection of the members of the public.

Mental health

Describes the capacity of an individual to interact with other people and their environment in ways that promote their sense of wellbeing, enhance their personal development, and allow them to achieve their life goals.

Mental Health Act 1986

Legislation concerning the treatment and protection of people with a mental disorder in Victoria.

Mental health professional

Staff of mental health services with professional training and qualifications, and experience in working with consumers who have a mental illness. Mental health professionals include: social workers, psychiatric nurses, psychiatrists, medical officers, occupational therapists and psychologists.

Mental health services

See: *Public mental health services*

Mental Health Review Board

The Mental Health Review Board is an independent tribunal established under the *Mental Health Act 1986*. Its main purpose is to hear appeals from, and regularly review the involuntary status of, all people subject to involuntary treatment orders, and including people on Community treatment orders.

Mental illness

A person is described as having a mental illness when their thoughts, feelings and behaviour cause them or others distress and are not in keeping with their cultural background. Examples are schizophrenia, depression and anxiety disorders.

Mobile support and treatment service (MSTS)

A multidisciplinary community based mental health service that supports and treats consumers who have experienced many psychiatric crises, have associated psychiatric disability, and are at risk of readmission to hospital without this support.

Multidisciplinary team

Mental health professionals employed by a public mental health service who work together to provide treatment and care for people with mental illness. They include social workers, psychiatric nurses, psychiatrists, medical officers, occupational therapists and psychologists.

Occupational therapists (OTs)

Health professionals who are core members of the multidisciplinary team and work in both community and inpatient settings. OT's have specialist training in the assessment and development of occupational performance and environment. They use a range of therapies and techniques to assist people to participate meaningfully in purposeful activities and in self-care, daily living, vocational, leisure and social domains of life.

Patient

The word patient has a specific meaning under the *Mental Health Act 1986*. It refers to consumers receiving treatment on an involuntary basis under the *Mental Health Act 1986*, including involuntary patients and security patients.

Prevention and Recovery Care Units (PARC)

These are sub-acute clinical units that provide a short term acute supported residential option, in partnership with the PDRSS sector, for people experiencing a significant mental health problem requiring intensive support but who do not need a hospital admission.

Psychiatric assessment

A thorough assessment of a consumer by a mental health professional which includes identifying a person's current mental state, personal history, social history, social situation and any relevant past psychiatric history. The psychiatric assessment enables selection of the most appropriate form of treatment for the consumer.

See: *Mental state examination, intake assessment*

Psychiatric disability

The effects of mental illness that seriously impair functioning in different aspects of a person's life such as the ability to live independently, maintain friendships or maintain employment.

Psychiatric disorder

See: *Mental illness, serious mental illness*

Psychiatric inpatient service

Publicly funded psychiatric hospitals and psychiatric units of general hospitals able to admit involuntary and security patients as well as voluntary patients.

Psychiatric nurses

Registered nurses who specialise in nursing care and treatment for people with mental illness. Psychiatric nurses work in community mental health services and psychiatric inpatient services. Their role includes psychological and physical care, e.g. the administration of medication and counselling/support.

Psychiatric disability and rehabilitation support services (PDRSS)

Psychosocial rehabilitation and support services provided by non-government community agencies to people with psychiatric disability. Such services include housing support, day programs or pre-vocational training, residential services and respite care.

Psychiatrists

See: *Consultant psychiatrists*

Psychologists

Clinical psychologists have specialist training in the assessment of behaviour and mental functioning and in a range of interventions aimed at changing how people think, feel and act towards themselves and others. Clinical psychologists are not able to prescribe medication.

Psychosocial rehabilitation

A range of interventions aimed at improving a consumer's personal, domestic and social functioning so that they can live independently in the community.

Public mental health services

The range of mental health services providing local and statewide specialist treatment and support for people with mental illness and associated psychiatric disability. These services are provided free of charge by the government. They include child and adolescent mental health services, adult mental health services and aged persons mental health services and specialist statewide services.

Restraint

The restriction of a consumer's ability to move in situations where, due to a deterioration in mental state, the consumer may do harm to themselves or others.

Restricted hospital transfer order

An order made for a prisoner to be transferred from prison to an approved mental health service to receive involuntary treatment.

Screening

A term sometimes used in place of 'triage', screening enables a duty/triage worker to obtain enough information from the person requesting service to enable appropriate referral to services within or outside the public mental health system. The duty/triage worker will take responsibility for referring a person to an outside agency or arrange an intake assessment with the appropriate local mental health service.

Security patient

People who are on a hospital security order or a restricted hospital transfer order.

Serious mental illness

A mental illness in which a person's ability to think, communicate and behave appropriately is so impaired that it interferes with the person's ability to deal with ordinary demands of life. Without treatment and support, the outcome for the person may be significant impairment, disability or disadvantage.

Social workers

Health professionals who have a qualification in social work. They form part of the multi-disciplinary team where functions include counselling, advocacy, family work and social network development.

Public mental health services

Public mental health services target people of all ages with severe mental health problems and disorders that cannot be effectively treated and managed by primary care services. Public mental health services comprise both clinical and non-clinical (psychiatric disability rehabilitation and support) services.

Symptoms

Changes in a person's mind or body that indicate they may be suffering from a particular illness.

Triage

Mental health triage is provided for all potential consumers (or people seeking assistance on behalf of a person thought to have a mental illness) at the first point of contact with mental health services. Triage may also be used for assessment of current and former consumers who make unplanned contact with the mental health service.

Treatment

The use of professional knowledge and skill to bring about an improvement in the person's mental illness, or to lessen the effects of a mental illness and the distress and suffering that may accompany it.

Treatment plans

The *Mental Health Act* requires that each patient have a treatment plan. In developing treatment plans the authorised psychiatrist (or delegate) must take into account the wishes of the patient and, unless the patient objects, the wishes of any family member, guardian or primary carer who is involved in providing ongoing care or support to the patient.