Community Mental Health Case Management Procedure

Effective: 18 June 2019

1. Guiding Principles

The Great Southern Mental Health (GSMHS) is a specialist service providing inpatient and ambulatory care to mental health patients in the GSMHS Catchment Area.

The role of the Case Manager within Community Mental Health is to provide coordinated recovery-focused care that involves assessment, treatment and support to both voluntary and involuntary mental health patients, their carers or significant others with clear communication between those involved.

2. Procedure

People experiencing psychological distress will present to Community Mental Health (CMH) through a variety of means, including but not limited to General Practitioner (GP) referral, Mental Health Liaison Nurse (MHLN) and Emergency Department (ED) presentation, Triage presentation in CMH or referral from stakeholder agency.
All new referrals for treatment are to come via triage.

Mental Health patients awaiting discharge from Albany Hospital who have an existing case manager in CMH can be discharged to the care of that existing CMH case manager by the MHLN from an outlying medical bed or the Transition Nurse from the Authorised Psychiatric Unit (APU) using a Care Transfer Summary form (SMHMR916) or Discharge Plan. The discharge is to be tabled at the CMH multi-disciplinary team meeting.

Mental Health patients awaiting discharge from the Albany Hospital who do not have an existing case manager in CMH are to be referred via triage and discussed at the CMH multi-disciplinary team meeting. If a post discharge outpatient medical appointment for a new patient is made via triage or the administration team directly into WebPAS, a referral must first be opened in PSOLIS.

Triage

Upon presentation of new referrals to the service a comprehensive mental health assessment is to be completed by Triage or the MHLN using the 8 page assessment form (SMHMR902). Triage only can use the triage screen in PSOLIS as a substitute for the 8 page assessment form providing all information is completed in all screens. This is a requirement under the WA Health OD0526/14 State-wide Standardised Clinical Documentation (SSCD) for Mental Health Services.

All triage documentation is to include a comprehensive mental state assessment including a risk assessment and management plan (SMHMR905) known as the RAMP. If the consumer identifies as Aboriginal, where practicable the Aboriginal Mental Health Worker is to be consulted during the assessment and work up of the referral.

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After initial presentation, work up and/or assessment of the consumer is to be presented by a triage clinician to one of the Central and Upper Great Southern (CUGS) or the Lower Great Southern (LGS) intake meetings for the input of the MDT and allocation of an initial phase of care for treatment as a mental health patient. The patient is to be allocated a case manager at one of these intake meetings.

Patients re-referred post discharge to an existing CMH case manager is to be tabled at the intake meeting to ensure that the CMH case manager completes the 7 day discharge follow up.

Models of Case Management for Triaged Patients and Care Transfer referrals

Case management is delivered within different phase of care categories according to mental state examination, RAMP, and identified treatment goals using completed assessment tools (see below) and including consumer and carer feedback. If the patient identifies as Aboriginal, an Aboriginal Mental Health Worker is to be actively involved during the case management process.

The phase of care proposed is to inform the treatment goals. There are five (5) phases of care which is to inform the case management plan.

Phase of Care	Goal of care
Acute	The primary goal is the short term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder. **This is generally an inpatient admission.**
Functional Gain	The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a consumer with impairment arising from a psychiatric disorder.
Intensive Extended	The primary goal is prevention or minimisation of further deterioration, and reduction of risk of harm in a consumer who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.
Consolidating Gain	The primary goal is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance.
Assessment Only	The primary goal is to obtain information, including collateral information where possible; in order to determine the intervention/treatment needs and to arrange for this to occur if necessary (includes brief history, risk assessment, referral to treating team or other service).

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Clinicians must use the NOCCS measures: HoNOS, HoNOSCA or HoNOS 65+, the K10, and the LSP-16 (adult community only) scores to assign a phase of care at the start of the case management episode and when a care plan changes following a deterioration or clinical review.

If for some reason a full triage mental state assessment and RAMP has not occurred recently, the allocated clinician is to complete these on the 8 page assessment form (SMHMR902) and the RAMP (SMHMR905).

Case Management tasks

The Case Manager is required to complete specific tasks at each stage of the patient journey.

Once the client has been allocated to a case manager, the case manager will complete an initial assessment, RAMP and NOCCS measures, given a proposed phase of care which has been confirmed by the MDT and they are to be activated as a mental health patient in PSOLIS.

The case manager is responsible for ongoing treatment and at a minimum three monthly RAMP, NOCCS and phase of care reviews with an updated Management Plan. All case management documentation including the NOCCS measures must be printed and the hard copy placed in the patient medical record.

Activation to the service:

- Finalising the assessment for activation may involve discussion with either or both Triage or MHLN and the patient and/or carer (if appropriate) to clarify or add to aspects of the assessment information.
- The discharge planning process is to commence with the patient, their carer (if appropriate) and the multidisciplinary team at the time of activation.
- Discuss discharge goals and treatment options with the patient and their carers (if appropriate). The Treatment Support and Discharge Plan document (SMHMR907) can be a helpful tool to ensure patient and carer input into the case management plan.

Case Management Minimum Responsibilities:

- Ensure that allocated activated patients have a completed set of appropriate outcome measures (see above) and have been allocated a phase of care in the measures screen. The outcome measures and patient and carer feedback are used to formulate the Treament Support and Dischage Plan document (SMHMR907) and signed by the patient and the case worker, with copies of the signed plan given to the patient and placed on the consumer medical record. The treatment goals decided are then entered in to ‘Management Plan’ in PSOLIS electronically and finalized in the system, printed off and placed on the consumer medical record.
- At regular intervals (at least three monthly) every patient is to have a clinical review using the outcome measures with a revised Management Plan finalised as above.

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- Communicate and liaise with carers, Aboriginal Mental Health Workers and external service providers involved in the patient's care and treatment (including the General Practitioner (GP) and other staff members within the MDT who are providing specific therapeutic consultations). Write to the GP with an update on treatment planning. Place a copy of the GP letter on the patient medical record.
- Provide assistance to the patient and/or their carers to appropriately access additional health or disability support services or community resources. Where this is in place, identify an appropriate primary health care provider, in consultation with the patient/carer, and liaise regarding:
  - care planning
  - post discharge follow-up
  - agreed crisis management plans.
- Provide information, education, advice, assistance and evidence based therapy to patients and their carers. This is to cover mental health needs, proposed intervention, early warning signs and relapse prevention.
- Provide relevant information to external agencies as per confidentiality and privacy policy and in consideration of risk.
- Refer, or coordinate referral, to other specialists within and external to mental health services to ensure appropriate assistance is available to the consumer.

Involuntary Case Management on Community Treatment Order (Form 5A):

Community Treatment Orders (CTOs) are a less restrictive form of involuntary order where a person experiencing mental illness does not need to be detained at an authorized or general hospital to be provided with treatment as an involuntary detained patient. CTO's are for timeframes of up to three months, with the review process governed by the Mental Health Tribunal (Tribunal) under the *Mental Health Act 2014.*

CTOs require a supervising psychiatrist and a case manager who is the responsible practitioner. Involvement of the Aboriginal Mental Health Workers is essential for Aboriginal patients. CTOs are generally not successful unless there is cooperation between the case manager and the patient. **(See Chapter 5 of the Clinician's Guide to the *MH Act 2014*)**.

If allocated the case management of a patient on a CTO the Case Manager/ Responsible Practitioner must perform the following functions:

At commencement of CTO

- Initially spend time going through with the patient his/her rights and responsibilities under a CTO as well as the responsibilities and legal pathways for the treating team.
- When a patient is being made subject to a CTO, a personal support person nominated by the patient must be notified.
- Ensure there is a CTO management plan (Terms of the Order) which are to be aligned with the treatment, support and discharge (management) plan to which the patient, carers and significant others have input. That plan is to outline the expectations of the service and the wishes of the patient and their carer or family members.

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- The case managers are to make it clear that con-compliance with the plan may result in a breach or order to attend. The attachment to the Form 5A Terms of the CTO is to be given to the patient. The plan is not limited to what is in the terms of the order but is to be comprehensive from a bio-psychosocial perspective.
- Ensure that as soon as practicable, and within 14 days from when the Community Treatment Order (CTO) was made, the patient is advised or notified in writing about the date, time and location of the first appointment with the treating psychiatrist. The actual appointment date can be outside of the 14 days but must be within 21 days. Under the Mental Health Act 2014, appointments for Central and Upper Great Southern can be via tele-mental health if face to face is not possible. (If this notification does not occur, the patient is entitled to seek a review from the Tribunal on the basis that the notification failure impacted on his or her rights. This notification can be on the attachment to Form 5A – Terms of the CTO. Case managers are advised to book the supervising psychiatrist's appointment in advance via WebPAS and note in WebPAS that this is a CTO review appointment.)

During the CTO

- The patient must be examined monthly as the minimum. The case manager is responsible for booking this appointment 14 days prior to the monthly anniversary date if it has not already been done (see dot point 3 below).
- In case of non-attendance at the appointment within the 14 days book a further appointment within a full 7 days before the anniversary date of the CTO in case of further non-attendance of the patient. This is to enable sufficient time to search for the patient in the event of a second non-attendance and maximize the chances of attendance before the expiry of the required CTO review timeframes.
- At least one out of three of these monthly examinations must be conducted by the supervising psychiatrist. If the psychiatrist is unavailable for up to two of these examinations, the psychiatrist can request on a Form 5D that another medical practitioner or mental health practitioner conduct the examination and then provide a report as specified by the supervising psychiatrist. The medical practitioner or mental health practitioner must provide the written report and part of the report must address the issue of whether the person is to still be on a CTO. A copy of the report must be filed in the patient's medical record.
- The final CTO examination is to take place within the 14 days before the CTO expires. This examination is to be done by the supervising psychiatrist but booked by the case manager. Under the *Mental Health Act 2014* this can occur via tele-mental health for Central and Upper Great Southern if face to face examination is not possible.
- Case Managers are required to attend Mental Health Tribunal Hearings with the supervising psychiatrist, patient and other relevant support persons and/or carers.
- When entering a PSOLIS event for attendance at a Tribunal hearing, please select the < Meetings> and state attendance plus the outcome of the Tribunal hearing in the comments box.
- Include all Associates present at the Tribunal hearing in the PSOLIS entry if possible.

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Revocation of a CTO:

- If the CTO is revoked by the Tribunal or the supervising psychiatrist, the case manager can complete the revocation in PSOLIS and record the reasoning for revocation and by whom

Breach of a CTO

A breach is when a patient does not comply with the order – such as refusing medication or not attending the clinic even though the treating team have taken all reasonable steps to obtain compliance and encourage attendance.

- If the supervising psychiatrist decides breach is the only option a breach order (Form 5E) is to be completed and include the details of the non-compliance.
- The patient is to be given a copy of the order and given time to comply with the order. Compliance requirements must be clearly set out. In person follow up is recommended as part of this process.
- The next option in the event of non-compliance is an order to attend at a particular place and time in order to receive treatment. Again, transport and in person follow up is recommended.
- If this is not successful a Police Transport Order (Form 4C) can be issued, the patient can be detained in an authorised facility, or the order revoked.
- If a Police Transport Order is required, the GSMHS Road Transfer Procedure and WA Health MP0063/17 Requesting Police Assistance for Transport under the Mental Health Act 2014 must be followed.

De-activation:

- Once treatment is complete the patient is to be deactivated in PSOLIS.
- The case manager is to complete a final set of outcome measures and enter them into PSOLIS. Print out a NOCC summary sheet for the patient medical record and remove individual print outs of previous review NOCCs. (Please note that the client needs to be deactivated with a date that is within seven days of the planned deactivation NOCC, otherwise it will revert to a Review NOCC, and the Deactivation NOCC will still be required.) The Discharge section of the Treatment Support and Discharge Plan (SMHMR907**)** is to be completed with the client and their support person (if applicable) and a copy provided to them with the original to be filed in medical records.
- The clinician is to complete a final RAMP and document a mental state assessment in afinal service event.
- Discuss the discharge and planned de-activation at the MDT meeting. This discussion is to include consideration of alerts in PSOLIS and whether or not the alert is to be removed or upgraded and/or escalated to Health Information Management via the Business Manager to include WebPAS.
- Any existing management plans and/or discharge plans must be 'completed' in PSOLIS after the MDT meeting.

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- Subject to agreement from the MDT and finalization of all paperwork in PSOLIS complete a de-activation form and forward to the PSOLIS Local Security Administrator for processing.
- Complete a discharge treatment summary letter or Care Transfer Summary (SMHMR916) stating presenting issues, interventions, medication regime, current assessment, follow up services and ongoing recommendations.
- The discharge treatment summary letter or Care Transfer Summary (SMHMR916) is forwarded to the GP and referring agency if there is one. A copy is given to the patient (and/or carer if deemed appropriate) with a hard copy also placed in the patient's medical record.

Re-Presentation within three months following de-activation:

- Where it is possible and deemed appropriate for continuity of care, consumers who are re-referred to the service are to be allocated to their previous Case Manager.
- Discussion is to occur between the Triage team and the Case Manager as to whether the consumer needs to first be triaged or subject to the MDT agreeing is to be assessed by the case manager and activated as a mental health patient without first being triaged.

3. Definitions

Triage	A core function of mental health triage is to conduct risk assessment that aims to determine whether the patient is a risk of harming self or others as a result of their mental state, and to assess other risks related to mental illness As with other triage models, the mental health triage clinician must assign a category of urgency to the case as per the 5-point Australasian Triage Scale.
HoNOS	Health of the Nation Outcome Scale, a 12 item instrument to measure progress towards a target set by the United Kingdom's Department of Health. The primary goal of the HoNOS is to measure the health and social functioning of mentally ill people for the 18-64 years age group.
HoNOSCA	The HoNOSCA is a 15 item instrument developed by the by the Royal College of Psychiatrists in 1999 to measure the outcomes of emotional and behavioural disorders in children and adolescents. The primary goal of the HoNOSCA is to measure the symptom severity and social functioning of the consumer over the preceding two weeks. The HoNOSCA was modelled on the HoNOS.
HoNOS 65+	The HoNOS 65+ is a 12 item instrument developed by the by the Royal College of Psychiatrists in 1999 to measure particular physical and cognitive problems affecting older people. The primary goal of the HoNOS 65+ is to measure specific mental health issues that occur in older people such as agitation and restlessness, delusions occurring in the presence of dementia, the phenomenology of depression and incontinence. The Royal College of Psychiatrists found that the HoNOS 65+ was able to discriminate between people suffering from organic and functional illnesses.

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LSP-16	The Life Skills Profile (LSP) is a 39 item clinical outcomes instrument that measures the life skills of how successfully people with schizophrenia or with a chronic mental illness live in the community. The instrument aims to assess constructs relevant to the survival, function and adaptation of consumers with schizophrenia, using specific and jargon free items to assess distinct behaviours.
PSOLIS	Psychiatric Services Online Information System – the mental health electronic patient information system.

4. Roles and Responsibilities

The **Clinical Director and Manager GS Mental Health** is to develop systems to ensure that all WACHS GS Mental health staff (medical, nursing and allied health) are provided with an orientation to the Case Management Site Instruction by their line manager.

The **GS Mental Health staff** are to operate within the parameters of the Case Management Procedure and provide timely feedback to line manager of any risks or problems associated with the model of case management.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

Periodic file audits and PSOLIS audits will be undertaken to review compliance with care planning and outcome measures and to monitor the governance of CTO's in accordance with the *Mental Health Act 2014.*

Monitoring of compliance with this document is to be carried out by Team Managers annually through manual audit of paperwork.

This procedure is to be reviewed every two (2) years.

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7. Standards

National Safety and Quality Health Service Standards – 2.6, 6.3, 6.8

EQuIPNational Standards - 12.1.1, 12.1.2, 12.2.1, 12.2.2, 12.3.1, 12.4.1, 12.8.1, 12.8.2, 12.9.1, 12.10.1, 10.10.2.

National Standards for Mental Health Services - 1.4, 1.6, 1.7, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 1.15, 2.3, 2.5, 2.11, 2.12, 2.13, 3.1, 6.1, 6.2, 6.3, 6.5, 6.6, 6.7, 6.8, 6.9, 6.10, 6.11, 6.12, 6.13, 7.1, 7.2, 7.4, 7.5, 7.6, 7.7, 7.8, 7.9, 7.10, 7.11, 7.12, 7.13, 10.1.1, 10.1.2, 10.1.3, 10.1.4, 10.1.6, 10.1.7, 10.2.3, 10.3.1, 10.3.2, 10.3.3, 10.3.4, 10.3.5, 10.3.8, 10.4.1, 10.4.2, 10.4.3, 10.4.4, 10.4.5, 10.4.6, 10.4.7, 10.4.8, 10.5.5, 10.5.7, 10.5.9, 10.5.11, 10.5.12, 10.5.13, 10.5.17,10.6.1, 10.6.2, 10.6.3, 10.6.4, 10.6.5, 10.6.6, 10.6.7.

8. Legislation

Mental Health Act 2014

9. References

Clinicians Guide to the *Mental Health Act 2014*

10. Related Policy Documents

WACHS Assessment and Management of Interhospital Patient Transfers Policy
GSMHS Road Transfer Procedure

11. Related WA Health System Policies

MP0063/17 Requesting Transport Officers and WA Police Assistance in Transporting Mental Health Patients Policy

MP0095 Clinical Handover Policy

OD0526/14 State-wide Standardised Clinical Documentation (SSCD) for Mental Health Services

12. WA Health Policy Framework

Mental Health Policy Framework.

This document can be made available in alternative formats on request for a person with a disability

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