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# **Victoria's Mental Health Services**

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**Improved Access Through**

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**Coordinated Client Care**

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## Acknowledgments

This document was produced in consultation with staff, carers and consumers of Victoria's mental health services. Regional Psychiatric Services Managers, clinical staff of all disciplines, and staff of psychiatric disability support services, gave valuable advice on drafts of the document, and their contribution was much appreciated. Particular thanks are extended to members of the Client Services Reference Group, and to North Eastern Metropolitan Psychiatric Services for use of their Intensive Case Management Policy and the consumer report *Our Opinion Counts*.

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# Minister's Foreword

Design and production by H&CS Promotions Unit.

In April 1994 I launched *Victoria's Mental Health Service: The Framework For Service Delivery* confident that the document would provide a sound guide to the reform and reshaping of mental health services. I reiterated that the Government has made improvement of the treatment and care of people with a mental illness one of its highest priorities.

The Framework document clearly indicates that a consistent approach to case management would be developed to ensure client care is coordinated. This follows international best practice and is in line with the National Mental Health Policy which affirms that the continuity of care for people with mental illness provided by case management is an essential feature of a quality mental health service.

The publication and implementation of this document, *Improved Access Through Coordinated Client Care* is the next step in ensuring that coordinated and consistent services are delivered to people with a serious mental illness in Victoria.

The policies and procedures presented in *Improved Access Through Coordinated Client Care* provide a common approach to service delivery, including coordinated care through case management for all clients receiving public mental health services. The document provides detail of the *Client Services Model*, identify-

ing functions to be undertaken by staff from reception to case closure. It also introduces a system of case management designed to ensure that service provision for each client is coordinated across different service types and settings.

I am confident that this will be a valuable resource for our staff, providing clear directions for quality client service delivery.

Most importantly, this is a further commitment to the improvement of care provided by public mental health services to those Victorians with a serious mental illness.

The Hon. Marie Tehan, MP  
MINISTER FOR HEALTH



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# Introduction

The need for a common approach to the delivery of mental health services across the state is highlighted in the April 1994 document *Victoria's Mental Health Service: The Framework for Service Delivery*. This document also accords case management a central role in ensuring continuity of care for clients.

A consistent approach to service delivery including a core role for case management has benefits to all those with a stake in how mental health services are provided. It is recognised that many clients who use public mental health services will only experience one episode of mental illness and will recover, having no need for further use of these services. For these clients case management may be no more than a simple tracking and monitoring of their progress through the service system. Others will have greater and more protracted involvement with the service system. Consumers and carers have long raised concerns about unresponsive and poorly coordinated services. Inquiries into institutional practices, the Statewide Clinical Audit, and Coronial inquiries of recent years have indicated the inadequacy of procedures and practices for case management.

Clinical staff and service managers have sought to redress this situation and to improve the way services are provided. Over time, individual services have developed their own guidelines about how clients should enter and move through the service. However, in the absence of a consistent approach, these processes can vary even across the same type of service. For example, service provision may or may not be based on an assessment which takes account of aspects of the client's living situation, such as available social supports and quality of housing, which are relevant to clinical progress. Similarly, a number of community mental health services have established their own policies regarding the provision of case management but the expectations of this role have differed across services. As a consequence, in one setting the term

case manager could refer to a staff member who took responsibility for ensuring his or her client received needed services whereas in another setting, the term could mean a staff member who was primarily a contact person or liaison point.

It is reasonable to expect that clients, carers and other service providers should know what processes will be followed when assistance is sought from public mental health services, and that procedures are consistent across different services. Clinical staff equally have an interest in clarification of their roles and responsibilities at different stages of service delivery.

The Psychiatric Services Division has acknowledged the imperative to put in place a common approach to service delivery which sets ground rules for how clients move through public mental health services. The ground rules should clarify the different stages of service delivery and their functions. Case management will be accorded a key role in coordinating services for individual clients and providing continuity of care.

The purpose of this document is twofold. Firstly, it identifies a common approach to service provision. Called the *Client Services Model*, this approach establishes a basis for the planned and orderly provision of services to clients across the service system, using a consistent set of phases and functions. Secondly, the document clarifies the role of case management as the linchpin in ensuring individualised service delivery, and describes the responsibilities of case managers in public mental health services.



# The Client Services Model

## A Common Approach to Service Delivery

The need for a common approach to service delivery is characteristic of all human services in the public sector, irrespective of the client group or type of service. This has occurred within services for people with physical illnesses, sensory disabilities or educational problems. The services provided have ranged from work retraining and provision of public housing, to guidance and support to new parents. The organisation of service delivery is likely to have a number of features which will be similar across different human services as well as others unique to the particular client group or service type.

A common approach to service delivery for public mental health services must take account of the nature of the service system and the service requirements of its clientele. The service system consists of a number of different elements (see figure 1). During the course of their illness, a client may require use of different clinical services, including inpatient as well as community-based services. Furthermore, some treatment services may be provided by clinicians in the private sector, such as general practitioners and private psychiatrists through shared care arrangements with community mental health services. The service needs of people with serious mental illness and other disabling psychiatric conditions typically include disability support as well as treatment, with some needs being met outside public mental health services. Examples would be appropriate housing, leisure activities, and job placement and support. Finally, some people will have only a brief involvement with the services, while for others, this will be extended over a much longer period.

The challenge of establishing a common approach to service delivery is not new to public mental health services. All have procedures in place to screen requests for assistance, assess clients' needs and provide the most appropriate service response. For instance, all

community mental health services have duty and intake systems for handling new referrals and regularly review client progress in multidisciplinary team meetings. Similarly, inpatient services have well-established procedures for assessing clients on admission and for formulating and reviewing treatment plans. These procedures complement rather than replace the use of clinical expertise. What has been lacking to date however is consistency in the processes followed in different services. This inconsistency can lead to:

- Unnecessary confusion amongst clients, carers and other service providers.
- The absence of benchmarks with statewide relevance.
- An inadequate base for providing appropriate staff training.
- The lack of a single point of accountability for service provision to a particular client.
- Inconsistencies in ways of ensuring that client progress is monitored and reviewed on a regular basis.
- The lack of procedures to ensure that services to clients do not deteriorate when they move between services types or locations.

In developing the *Client Services Model* for public mental health services, a heavy emphasis has been placed on examining existing practice to identify a core set of processes and functions to guide service delivery. Much of the content of the model will therefore be familiar to staff of public mental health services.

*This Client Services Model:*

- Takes account of existing best practice.
- Makes explicit the processes that are to be followed and functions undertaken in providing services to clients.
- Identifies standards to be met in service delivery, which in turn set benchmarks for quality assurance purposes and a foundation for focused staff training, for instance, in undertaking client needs assessment.

Figure 1: Victoria's Mental Health Services—The Framework for Service Delivery (from: *Victoria's Mental Health Service: The Framework for Service Delivery*, 1994)

- Deals with systemic requirements such as ensuring a point of responsibility for individual clients and establishing monitoring and tracking mechanisms.
- Provides a basis for generating data for service planning and development.

# An Overview of the Client Services Model

The *Client Services Model* identifies what should happen after a potential client or referring agency makes contact with an area mental health service. The Model charts the functions undertaken from reception through to case closure. It builds upon a single point of entry to the service, including inpatient services, with referrals being channelled through the relevant area community-based service (see figure 2). During business hours, this will be the local community mental health service and after hours, the area inpatient service, which may mobilise the Crisis Assessment and Treatment (CAT) service.

Figure 3 shows the key components of the Model. As can be seen, service activity in response to a referral is grouped into four phases, with each phase having particular functions to be undertaken:

- Reception
- Duty
- Intake
- Service delivery

Completion of each phase results in a decision being made about whether the client moves to the next phase or is referred to an external agency. A detailed description of each phase and its functions is given under *The Client Services Model in Practice*.

The first three phases of Reception, Duty and Intake cover initial contact with the public mental health service system. The functions undertaken during these phases enable clarification of the appropriateness of the referral for public mental health services, with referral being made to more suitable agencies where necessary.

The fourth phase, Service Delivery, is the crux of the service system. Important features of this phase are:

- The appointment of a clinical staff member, generally from the area community mental health service as the client's casemanager.
- The requirement that each client has a comprehensive needs assessment undertaken.
- The development of an Individual Service Plan (ISP) which is reviewed on a regular basis.

Figure 2: Community-Based Service Delivery (from: *Victoria's Mental Health Service: The Framework for Service Delivery At a Glance*, 1994)

Figure 3: Client Services Model

The client's case manager is responsible for ensuring that these latter two requirements are met.

Public mental health services provided during the Service Delivery phase may include inpatient as well as community-based services, with the case manager liaising with inpatient services as required. Some of the client's service needs may also be met outside the public system. For example, particular treatment needs may be met by private practitioners such as general practitioners, and community support needs by non-government organisations.

Finally, a case will be closed when a client is no longer using public mental health services. Typically this would include clients whose condition has improved to the point where they no longer need treatment or whose clinical and disability support needs are being covered by services other than public mental health services. Where referral is made to services external to public mental health services, appropriate follow up will be undertaken to ensure duty of care requirements are met. Case closure would not occur while a client's case manager was still monitoring the success of their transfer to alternative services.

## Responsibilities of Area Service Managers

In order to implement the *Client Services Model*, the Area Service Manager will be responsible for ensuring that each community mental health service has established the following:

- Reception staff are appropriately trained for their role, and know when to refer callers to the Duty Worker.
- A Duty and Intake System is in place and clinical staff rostered as Duty and Intake Workers are familiar with the responsibilities of these roles.
- The clinical staff who will undertake case management are identified.
- Training opportunities to ensure the development of

relevant skills to undertake the role are identified, including training in the *Mental Health Act 1986*, negligence, consent and confidentiality.

- A case manager is identified and appointed for each registered client of public mental health services, including current inpatients and inpatients from the catchment area not registered as clients of the community mental health service, and CAT service clients.
- An ISP is formulated with each client based on a comprehensive client needs assessment, and which indicates the level of case management support required.
- Processes are in place for ensuring that each client's ISP is reviewed regularly by the multidisciplinary team at least six monthly.
- That the ISP is formulated and discussed by the multidisciplinary team and approved and signed off by the team consultant psychiatrist.
- A record of all clients of the service is kept by the service with copies of all assessments, plans and closure procedures.
- In conjunction with the Director of Clinical Services (DCS), monitoring and reviewing workload levels, including relief cover arrangements, in relation to the provision of case management services.
- In conjunction with the DCS, monitoring and evaluation of service performance against established indicators.
- Liaison arrangements are established between community case managers and inpatient services for clients from the local community mental health service, taking into account distance difficulties.
- Protocols are established between inpatient facilities and community-based facilities where the clients are from out of the area or have no forwarding address, and will include a dispute resolution mechanism.

## Responsibilities of the Director of Clinical Services and Their Delegates

Authority for day to day clinical decision making is delegated by the DCS who has overall responsibility for clinical leadership. In general, authority in relation to significant and complex clinical decisions will be delegated to the consultant psychiatrist or the senior clinician. Like Area Service Managers, DCS have additional specific responsibilities in relation to the *Client Services Model*. These responsibilities are for ensuring that:

- Clinical staff appointed as case managers are suitably qualified to undertake the role.
- Case management meets appropriate clinical standards, for instance, the quality and appropriateness of ISP's, and the involvement of the client and carer as appropriate.
- Disputes are resolved regarding assessment, planning, implementation, monitoring, review, and closure in a reasonable manner so that the requirements of duty of care are satisfied.
- The appropriate recruitment, supervision and review of case management practices are in place.

# Continuity of Care

## Case Management at a Glance

- Coordinated care for each client of public mental health services will be assisted through effective case management.
- Each client will be assigned a case manager at entry to the service delivery stage of any public mental health service.
- Each client will be provided with a psychiatric assessment, which will include a Needs for Service Assessment, as the basis of their Individualised Service Plan.
- Every client will have an Individualised Service Plan outlining goals, strategies and responsibilities, developed with their case manager.
- The case manager will be responsible for facilitating implementation of the individual service plan.
- Each client will have their Individualised Service Plan formally reviewed at least six monthly.
- When a client no longer needs public mental health services and appropriate follow up has occurred the case will be closed.

## The Role of Case Management

Continuity of care is a critical component of effective service provision for people with serious mental illness and its achievement is a key goal for public mental health services. Mental illness is often episodic in nature and associated with varying degrees of ongoing disability. As already noted, at different times a client may need to use inpatient and community-based services, and have access to a range of disability support as well as clinical services. Continuity of care requires that service provision for the individual client is coordinated across service settings, whether hospital or community-based, and across different types of services, such as treatment, rehabilitation and accommodation support.

Case management is well established as an effective way of ensuring continuity of care for people with

mental illness. It is important to note that it does not refer to the management of clients, but to the management of the provision of services. For the individual client, case management includes ensuring that services are provided which are appropriate to his or her treatment and support needs, and also that service provision is timely and effective. Because of the nature of mental illness, case management for clients of public mental health services is primarily a clinical function. Typically it relies on a collaborative treatment alliance being formed with the client, which in turn draws on the professional skills and expertise of clinically trained staff. Whilst the role has elements of brokerage, the more significant components are:

- Engaging collaboratively with clients.
- Understanding and responding to the client's clinical needs, which may fluctuate rapidly.
- Identifying and negotiating access to services to meet the client's needs. As some of these services are likely to be outside public mental health services, case management also includes providing secondary consultation.

For less disabled clients, the case manager's role may essentially be one of monitoring the client's progress, and providing consultation as required. A similar role will be undertaken by case managers of clients whose treatment or disability support needs are largely met outside public mental health services such as from private practitioners or non-government disability support services.

In recent years, case management has become a more regular feature of service delivery by community mental health services in Victoria. There has been debate however, about whether all clients of public mental health services should receive case management, and who should undertake this role. Services have also varied in how the responsibilities of case managers have been defined and undertaken. Staff training and development activities in relation to case

management have been ad hoc and fragmented. Overall the system of case management has lacked consistency and there have been no generally applicable standards of practice.

The April 1994 document *Victoria's Mental Health Service: The Framework for Service Delivery* sets out clear policy about the place of case management in public mental health services in Victoria. The policy applies directly to Departmental services, and will soon form part of service agreements for clinical services funded, but not managed, by the Department.

The document notes that each client is to have a clinical staff member appointed as their case manager. The case manager's responsibilities include facilitating assessment and service provision to meet the client's treatment and support needs, and providing continuity of care through the coordination of service delivery across time and setting.

## Differing Client Needs

Concerns have been raised about the resource implications of the appointment of a case manager for each client of public mental health services. An analysis by the Psychiatric Services Branch of 1991-92 data on service utilisation and Project Focus findings on client disability levels in the adult program area suggests however that not all clients will require the same level of case management support. The data indicate that around 70 per cent of clients of public mental health services in 1991-92 had previous contact with either public inpatient or community-based mental health services, and were therefore defined to have ongoing illness. These clients were grouped according to the level of support required. On a statewide basis, the analysis showed that the two most numerous groups were those with low or medium levels of continuing disability. Clients with low levels of continuing disability were approximately 42 per cent of those with ongoing illness, and would require correspondingly

less intensive case management support. The major activity of the case manager for clients in this group would be to ensure monitoring and review of their ISP.

The second group with ongoing illness comprised around 46 per cent of clients with medium levels of continuing disability, whose needs for case management support would be more intensive. Case managers of these clients would have to be active in establishing and maintaining a therapeutic treatment alliance with the client in order to develop and implement an appropriate ISP. The final group, comprising approximately 12 per cent of clients with ongoing illness, had high levels of continuing disability. This group includes those who are inpatients in extended care beds or residents of Community Care Units, as well as clients living in other types of community accommodation such as Supported Residential Services. Community clients will require intensive case management support. This may well be provided by an extended hours Mobile Support and Treatment services (MST) working with clients on an outreach basis.

It should be noted that the analysis presented here refers to clients known to have ongoing illness through previous contact with public mental health services. Of those clients who had contact in 1991-92, 30 per cent were new to public mental health services. Of these, 28 per cent went on to receive further treatment. Data are as yet unavailable however, on the nature of their disabilities and the level of case management required.

Services will differ in terms of the number of clients with different levels of disability, with some areas such as the inner city having higher proportions of clients with medium to high disability levels. The client mix in each area together with the range of services available will determine the adequacy of current resources to meet case management requirements. This will need to be monitored closely by staff responsible for service management.

Figure 4: Levels of Disability and Case Management Needs of Adult Clients with Ongoing Illness 1991–92

Clients of Public Mental Health Services	Levels of Client Disability	Proportion of Clients with Previous Contact with Public Mental Health Services	Case Management Response and Role of the Case Manager
70 per cent known to have an ongoing illness	Low	42 per cent	Less intensive case management. The case manager's major activity would be the monitoring and review of the client's ISP.
	Medium	46 per cent	More intensive case management. Case manager establishes and maintains an alliance with the client in order to develop and implement an ISP
	High	12 per cent	Very intensive case management, perhaps provided by a MST.

Figure 5: Continued Service Use By Adult Clients With First Contact With Public Mental Health Services 1991–1992

Proportion of 1991–92 Clients With No Previous Contact	Nature of Further Contact	
30 per cent	Further contact at least 12 months after first contact	28 per cent
	No further contact during 12 months after first contact	72 per cent

## Case Management in Practice

Public mental health services aim to maximise a client's recovery from illness and minimise any associated disability. Potential obstacles to effective service provision include problems with coordination and accountability, and service accessibility. Case management is a way of overcoming these obstacles by providing access to appropriate services in a timely and efficient manner.

A successful case management system ensures that service provision will be effectively managed from when a client begins to receive services through to case closure, where this is appropriate. Case management assists clients through the interrelated steps of entry, assessment, planning, implementation, monitor-

ing and review, and closure, which are the core functional components of the service delivery phase.

Services provided to the individual client may include acute or continuing care, in a hospital, residential or community setting. Through case management, care is coordinated across different service types and settings to ensure continuity of care.

## The Role of the Case Manager

Case management is a clinical service which draws on the casemanager's professional skills in engaging with a client and responding to his or her clinical needs.

The case manager is responsible for coordinating the system of care delivered to a client, and will:

- Establish a collaborative relationship with the designated client.
- Ensure that clients who have urgent needs or require immediate treatment or action, are attended to immediately.
- Ensure that the client receives a comprehensive assessment through the coordination of psychiatric and Needs for Service Assessments, and where necessary, more specialised needs assessments.
- Develop a plan, based on assessment of the client, which contains clearly specified goals, strategies and responsibilities for action and ensure its implementation.
- Monitor and review the plan.
- Provide direct clinical services where appropriate, including individual, group, and/or family treatment.
- Monitor periods of inpatient care and appropriate discharge arrangements.
- Facilitate access to services relevant to the client's assessed needs.
- Liaise with, and provide feedback to, professionals and others, including carers, who are involved with the client. This must be in line with the requirements of confidentiality, unless the client has consented to the provision of information to others.
- Ensure that referrals to Protective Services and the Police are made as appropriate.
- Ensure appropriate follow up after the referral of a client elsewhere.
- Ensure case closure where appropriate.

## Responsibility and Accountability of the Case Manager in the Multidisciplinary Team

The introduction of a case management system across public mental health services raises questions about the legal responsibilities of staff in undertaking the case management role for a client. It should be noted that legal responsibility is not the sole province of one health professional in relation to one client. Different

clinicians in the multidisciplinary team may have varying degrees of responsibility for a particular client depending on the particular action or event in question.

The case manager, as well as providing services directly to an individual client, is responsible for coordinating the services delivered to that client. Each clinician in the team will be individually responsible for their own work in relation to the client and will be responsible for communicating with the case manager and other members of the team about the client's changing needs or any other relevant information. The case manager will be responsible for making sure that the client has access to the range of area mental health services required and negotiating for other needed services.

Responsibility for the patient's treatment while an inpatient, or when on a Community Treatment Order, rests with the Authorised Psychiatrist. A psychiatrist must also be available to provide expert consultation on the care or diagnosis and treatment of community clients not subject to a Community Treatment Order whose case managers are not psychiatrists. In some situations, this consultation may be provided by a private psychiatrist.

The Director of Clinical Services (DCS) for the area mental health service has overall responsibility for the clinical standard of case management, including the comprehensiveness of assessment and appropriateness of ISPs, and for ensuring that staff appointed as case managers have the requisite skills to undertake this role, and act in accordance with the *Mental Health Act 1986*. Implementation may be delegated to the Senior Consultant Psychiatrist or other Senior Clinician of the community mental health service providing case management. In either situation, processes are to be established to ensure that clinical standards are being met.

The case manager is responsible to the DCS for undertaking case management tasks and for the standards of case management.

Appendix 2 provides answers prepared by the Legislation and Legal Services Unit of Health and Community Services to questions about the legal responsibilities of mental health professionals

## Intensity and Duration of Case Management

The level of intensity of case management support will vary according to the needs of the individual client. Those clients with complex, multiple needs who require a range of services, will clearly need more intensive support from a case manager than will clients with less complex needs.

The intensity of case management will vary as a client's needs fluctuate, often rapidly, between acute and continuing care. Similarly, case management must be flexible in order to meet the client's needs for whatever period of time support is required.

It is very common for a client to receive clinical support from public mental health services at the same time as attending a non-government organisation (NGO) day psychosocial rehabilitation program, and/or receiving NGO accommodation support. In these instances, the role of the case manager will primarily be one of monitoring, by liaising with the NGO key worker to ensure that the functions of service delivery are carried out.

The duration of case management will also depend on the needs of the individual client. The monitoring and review of goals and strategies will indicate when the client no longer requires public mental health services, case management can be withdrawn, and the case closed.

## Who Can Be a Case Manager?

Case managers will be appointed from the following clinical staff, generally at community-based services: psychiatric nurses, medical staff, psychologists, occupational therapists and social workers. Any exceptions will need to be approved by the relevant DCS. All inpatients and Crisis Assessment and Treatment (CAT) service clients will be allocated a case manager, generally from the community mental health service in the most relevant area.

In some circumstances it may be appropriate for certain clinical staff to be excluded from the role of case manager to maximise the best use of clinical skills and the efficiency of service delivery. For instance, staff of CAT services will not undertake a case management role, but would nominate a case coordinator for each client who would liaise with the client's case manager.

A case manager will, wherever possible, work with a client across service and geographical boundaries. For instance, a case manager will continue their role if the client is admitted to hospital. The case manager will work closely with inpatient and CAT service staff to ensure consistency of services and involvement of community-based staff in treatment, planning and management, and discharge planning. This will involve contributing to relevant case meetings.

When a client moves from a particular area, and can no longer be supported by the case manager of that service, this case manager will be responsible for a formal transfer to another service and for ensuring that case management is continued in a manner which is least disruptive to the client.

Some clients move continuously between two or more regions, making consistent service delivery difficult, and raising questions of accountability and responsibility. In this instance, one case manager must be appointed. The decision as to who will take on this role

must be initiated by the region currently responsible for the client and involve all services/regions with an outcome reached that is in the best interests of the client. In determining which service/region takes case management responsibility, the following would be taken into account:

- The client's preferred service/region.
- Any existing relationship between client and worker/s.
- The service/region to which the client most frequently returns.
- The location of family members, significant others and services.

In some instances the client or the case manager may request that an alternative case manager is appointed. The DCS, or their delegate, must nominate a member of the clinical staff to receive and review such requests, and oversee the appointment of an alternative case manager where it is appropriate to do so.

## Case Management Skills

The DCS for the area mental health service carries overall responsibility for ensuring that case managers are suitably qualified and skilled to undertake this role, although implementation tasks may be delegated to the Senior Consultant Psychiatrist of the local community mental health service.

Case managers need to have:

- Appropriate clinical training as defined by the standards of their respective professional group.
- Appropriate training in respect of the *Mental Health Act 1986*, duty of care, consent and confidentiality.
- An ability to assess the urgency of situations and to initiate appropriate action.
- An ability to appreciate when referrals to agencies such as Police and Protective Services are appropriate.
- An understanding of the aims and the practice of case management.

- An ability to work collaboratively with clients, carers and other professionals.
- Communication and negotiation skills.
- An understanding of the network of mental health services and how to work within it on behalf of clients.
- An ability to establish a supportive relationship with the client.

*Coordinated care for each client of public mental health services will be assisted through effective case management*

# The Client Services Model in Practice

This chapter describes how case management will be applied within services provided by Health and Community Services (H&CS). It provides guidelines for the use of the *Client Services Model* by describing each of the phases of the Model and its functions. The guidelines also identify benchmark standards to be met in the provision of public mental health services.

As has already been stated, the *Client Services Model* provides a common approach to the delivery of services to clients of public mental health services. Its primary objective is to ensure that client service needs are met effectively and efficiently through use of a core set of processes and functions.

The Model also enables data to be generated on the use of services, and for links between service delivery and service planning to be strengthened.

## Decision Points

There are a number of points within the *Client Services Model* at which a decision is made which affects a client's movement through the service system.

The major decision points are identified on the diagram of the Model (figure 3) and occur after the following functions are undertaken:

- Reception
- Duty screening
- Determining service response following an intake assessment
- Review of the client's progress within the service delivery phase

Each point requires that a decision be made about whether a client's service needs are best met through public mental health services or another more appropriate service. At each point the service activity may continue or the case may be closed. The decision points also enable the tracking of clients through the service delivery process by monitoring decisions made

at each point. Decisions made must be based on sound clinical judgement and take account of duty of care requirements.

## Reception

Reception is the phase at which any individual first makes contact with public mental health services. Callers will include potential clients, family members, carers, service providers and members of the public. Some requests will be able to be met at reception, and not have to proceed any further. For instance, persons seeking information or the telephone numbers of another service would have their request met and no further action need be taken.

It is envisaged, however, that all contacts needing a mental health response and unable to be resolved at this level would be directed to the duty worker at the community mental health service during business hours. Outside of business hours, calls relating to psychiatric emergencies or requests for admission would be received by the switchboard operator and passed on to the designated clinician at the psychiatric inpatient service. Callers who do not require an out of hours response would be requested by the switchboard operator to contact the community mental health service the following working day.

## Duty

Duty is the phase during which contact is first made with a *clinical staff member*. Based on an initial screening, the duty worker will guide the person making contact to the appropriate service. If this service is outside public mental health services, a referral may be required to another organisation, including public sector, voluntary, local government, or private agencies. Examples would be a private psychiatrist, private counselling service or non-government disability support service. Alternatively, the duty worker may consider that public mental health services

could offer the most appropriate service for this particular person, either exclusively or in partnership with other services. In this case a more detailed assessment would be provided through the Intake process.

There are two functions within the Duty phase:

### Screening

Screening enables the duty worker to obtain enough information to guide the person to an appropriate service, either within or outside public mental health services.

Screening is undertaken by clinical staff as it is a highly specialised role which requires skills in the initial assessment of need, often with minimal information, and a sound knowledge of available services. Skilled negotiation may also be required to make an effective referral to another agency and maximise a positive outcome for the client. Screening includes an initial assessment of risk and urgency factors.

The duty worker will use his or her professional skills to respond to the difficulty that clients may have in making their first contact with public mental health services. The duty worker will also take responsibility for making a referral to an outside agency, should this be appropriate, or alternatively, for ensuring that an intake assessment is arranged for the client which takes account of any urgency.

### Contact Registration

At this point the duty worker must record all contacts made with the public. Staff will complete a contact form for each client, whether or not he or she has had previous contact with the service, and whether or not the contact proceeds to intake.

## Intake

The aim of the Intake phase is to obtain sufficient information to assess the type and level of service response required from public mental health services in order to ensure that the client receives the most appropriate services. Typically this will entail an assessment based on face-to-face contact with the prospective client, either in the client's own environment, or at the agency. Intake may also lead to a referral to another agency.

The Duty and Intake phases will, in some circumstances, be concurrent. This is likely to be the situation where the urgency of intervention is critical for the well being of the client or others. If this occurs the functions of each phase must still be carried out. Intake for clients in crisis will generally be the responsibility of the area Crisis Assessment and Treatment (CAT) service, particularly if the duty screening indicates that the referred person may be in the acute stage of a mental illness, and a response by the community mental health service is not sufficient to meet the person's needs.

However, Intake for most clients will be undertaken by staff of community mental health services.

There are three functions within Intake:

### Registration

Client details will be registered when he or she has been referred to Intake for an assessment. Registration occurs at this point to ensure that:

- All information such as assessment material is stored and handled in such a way that confidentiality and security of the information is ensured.
- Clients who do not receive services from public mental health services can be tracked to determine if positive outcomes result.
- Information can be effectively retrieved if a person presents again at a later stage.

- The amount of work undertaken by Intake staff can be recorded and effectively managed.

## Intake Assessment

The Intake assessment is the initial assessment offered to a client in order to determine his or her needs and the most appropriate service immediately required. The type and duration of the assessments will vary according to the client's circumstances. In all instances it will involve a psychiatric assessment.

The assessment will address the following areas:

- Presenting problem.
- Why is the person presenting now?
- Risk Assessment.
- Mental State Examination.
- Is the presenting problem a mental health problem?
- Psychiatric history.
- Family/Living Situation.
- Major social or psychological stressors.
- Physical Assessment.
- Drug and alcohol use.
- Special characteristics of the person which need to be taken into account such as Non-English Speaking Background and additional disability.
- Developmental issues and family function.
- Urgency of intervention.
- Preferences for case manager and other clinicians in terms of gender, ethnicity, previous contact, and treatment location.

It may be appropriate to include additional screening measures such as a brief disability measure and/or a Response Difficulty Checklist.

At this point clients should be informed of their relevant rights as set out under the *Mental Health Act 1986*. For example, a client can request that the service arranges for a second opinion about his or her psychiatric condition, and can choose the psychiatrist they would like for a second opinion. Clients should also be

informed of their right to have a friend or advocate support them through all phases of their contact with the public mental health services. Clients should also be informed of the requirements in relation to consent.

## Determine Service Response

On the basis of the Intake assessment, a decision will be made by the intake worker, or the team responsible for intake decisions, about the type and level of response from public state mental health services. The Consultant Psychiatrist has overall responsibility for intake decisions and the level of response from public mental health services. The initial assessment may indicate that referral to another agency would be more appropriate, or that information provided may be sufficient for no further action to be needed.

Comprehensive documentation must be kept in relation to the decision and rationale made at this point, whether or not the person becomes a client of the public mental health service system.

The intake worker will be responsible for making an effective referral to another service, if appropriate, or alternatively ensuring that the case is presented at the relevant team meeting for appointment of a case manager and initiation of service delivery. The intake worker for a particular client may be appointed as the client's case manager. However this will depend on a number of factors including the needs of the client, the 'best fit' between client and case manager, and the relative case loads of clinical staff. The desirability of continuity of worker from the point of intake will also need to be taken into account. It is the responsibility of the Consultant Psychiatrist to ensure that these factors are given careful consideration when a case manager is appointed.

## Service Delivery

The case manager's role in service delivery will vary in intensity according to the needs of the client and will

range from coordinating and monitoring the client's straightforward progress through the service system to an intensive service for clients with more complex and multiple needs.

The following functions may occur simultaneously or sequentially.

### Entry

At this first point in the service delivery phase, a case manager will be assigned to each client, and initial contact made between them. The aim is to initiate a collaborative relationship with the client, and other significant people in his or her life where this is appropriate. It is this relationship that will enable the case manager to intervene to improve the client's situation.

The case manager will need to explain their role to other clinicians with whom the client is, or will be involved. The case manager's coordinating function should be clarified. If the client has been referred to the service from another professional, such as a GP, then direct contact should be made with that person to confirm the referral.

The case manager will initially have information from the intake assessment in relation to the client's current situation. It is important at this stage to attend to any issues or differences, such as differences in race or gender, that may alienate the client from the case manager or other clinicians. Similarly, it must be established whether any language difficulties or problems of understanding exist, and if an interpreter is necessary.

Clients in the Adult Program Area experiencing a psychiatric crisis will typically receive services from a CAT service, or in some circumstances from an inpatient service. In these circumstances it is the responsibility of the CAT service to contact the community mental health service to request the appointment of a

case manager as soon as is practical. The exception is where the client will have a short term involvement only and a decision has been made that case management responsibilities will be assumed by the primary clinician. Where an area CAT service has yet to be established, the designated clinician at the inpatient unit will contact the community mental health service to request the appointment of a case manager.

Whilst the client initially receives services from a CAT service or an acute inpatient service, the case manager will liaise with the treating team about the client's care until management is transferred to the community mental health service. At that point, the case manager will undertake the usual functions of entry as described above.

*Each client will be assigned a case manager at entry to the service delivery phase.*

### Assessment

Information gained through assessment forms the basis for the client's Individualised Service Plan (ISP), which in turn is the basis of implementation, monitoring and review.

It is not the role of the case manager to undertake every assessment needed by their client, but rather to ensure that a comprehensive assessment is undertaken and that this information is used in a meaningful way. It is essential that the range of appropriate service providers are involved in the assessment and review process. This may involve not only the case manager but also key workers in other disability support and primary health care services. At a time of reassessment for review, many of the categories may be reviewed with the consumer by a key worker from a disability support service, who has provided a range of services, whilst the clinical service has provided a more limited treatment and monitoring role. In other circumstances, the clinical services may have played a more major

role. It is essential that the consumers' preferences and choice are respected about who is involved and how the assessment of need and/or review is conducted. The Consultant Psychiatrist is responsible for ensuring that the client receives a comprehensive assessment. The type of illness and nature of disability lead to likely needs for service in a range of areas. If some are recognised, but others overlooked, the potential for maximum recovery and minimum associated disability is reduced.

All assessments will provide an accurate description of the client's personal and family situation, so close liaison with carers, family members and other workers is important. Consent to disclosure of information to carers and family members should be sought from the client. Otherwise disclosure must be limited in line with the requirements of confidentiality. The case manager will need to consider the cultural background, ethnic origins, means of communication and level of comprehension of the client and family to ensure a meaningful assessment that provides useful information.

A comprehensive assessment is therefore essential, and will involve the following types of assessment:

### Psychiatric Assessment

Significant parts of this may have been completed at Intake. If not, it must be fully addressed at this stage because it is crucial for determining the need for service of each client. The psychiatric assessment will assess the client's clinical status, noting evident symptomatology, formulating a diagnosis and identifying a treatment plan. The assessment usually entails a mental state examination, a detailed developmental and psychiatric history and an estimate of risk to self and others. A physical examination may be necessary to exclude contributing medical factors such as infections.

Needs for Service Assessment must also be completed as it is important to assess every client's needs for service in a variety of domains. Some of these domains may only be appropriate and accessible when an acute phase of illness abates and there are indications of how the person has responded to initial treatment. The following categories should be assessed to establish whether there is a need for services:

- Emotional and mental wellbeing
- Dealing with stress
- Personal response to illness
- Personal safety and safety of others
- Friendships/ social relationships
- Work/leisure/education
- Daily living skills
- Family response to illness
- Income
- Physical health
- Housing
- Rights and advocacy

Some areas to consider in each of these domains are presented in appendix 4. Needs will be noted from the perspective of the client, carer and practitioner, and will include any differences of opinion relating to those needs and their priority for action. A sample format for a Needs Summary is given in appendix 5. The Needs for Service Assessment applies to the Adult and Psychogeriatric program areas.

If the Needs for Service assessment indicates that a significant need exists, it may be necessary to undertake a further specialised assessment:

### Specialised Needs Assessment

This will be undertaken as a result of the Needs for Service Assessment. For instance, it may have become evident that the client requires an educational or vocational assessment to ensure referral to an appropriate service. This specialised needs assessment could

result in further assessment of cognitive skills, specific work skills and interests.

Every client will have a plan prepared based on the information from the psychiatric assessment and any areas of the Needs for Service Assessment shown to be unmet. Where the Needs for Service Assessment indicates that there are no unmet needs planning in that area is not necessary.

*Each client will be provided with a psychiatric assessment, which will include a Needs for Service Assessment, as the basis of their individual service plan.*

## Planning

The establishment of a management plan clarifies goals and expectations and identifies appropriate services for each client. An ISP must be developed for each client relating directly to the information provided by the client's assessment. For an inpatient, treatment plans provide valuable day to day direction for staff about treatment and care. Appropriate information from these plans will be incorporated into the ISP.

The case manager is responsible for ensuring that the ISP is developed.

For many the ISP may be brief and cover a limited number of areas. For others with complex needs the ISP will be more comprehensive. It is acknowledged that planning may apply to a family, particularly where young children are involved.

The ISP will detail:

- The current situation and definition of problem/s.
- The goals to improve the situation and indicators of their achievement.
- The strategies for achieving the goals.
- The person/s responsible for implementing strategies.
- The date of review.

The ISP will be developed in collaboration with the client and where the client has given consent to their involvement, with the client's carers, family members and service providers. The Director of Clinical Services (DCS) or their delegate is responsible for ensuring that the ISP meets appropriate clinical standards.

The plan must be written using clear and accessible terminology which can be understood by the client and/or carer. A copy of their ISP and Needs Summary would normally be made available to the client and, with the client's written consent, to agencies outside public mental health services which will be providing services to the client. The ISP is a tool to help the client, not an end in itself.

The case manager, and any other clinician on the multidisciplinary team, may initiate changes to the ISP based on any ongoing assessment material, or significant changes in the client's situation, for example hospital admission. The client too may request changes to the ISP. Significant changes must be endorsed by the multidisciplinary team, and approved by the DCS.

Where a client and/or significant others disagree about the content of a client's ISP, the case manager is responsible for negotiating a reasonable outcome from a clinical perspective, as well as from the viewpoint of the client and significant others. Similarly, the case manager would also be responsible for negotiating agreement between clinical staff who may differ on the client's service needs and how these should be met.

Where a negotiated outcome is not possible in either situation, the matter should be referred to the DCS for resolution.

*Every client will have an individual service plan, outlining goals, strategies and responsibilities, developed with their case manager.*

## Implementation

Implementation is the facilitation of the strategies developed in the ISP.

To achieve this, the case manager will need to:

- Liaise and consult with other services, such as non-government organisations (NGOs), GPs, generic services, and other psychiatric facilities to ensure the effective and efficient coordination of service delivery.
- Provide information and support to family carers.
- Work collaboratively with the client.

*The case manager will be responsible for facilitating implementation of the Individual Service Plan.*

## Monitoring and Review

Monitoring is the ongoing evaluation of progress of the strategies and goals identified in the ISP and is the responsibility of the case manager. The service manager is responsible for ensuring that the review process is undertaken within the specified time frame. The Consultant Psychiatrist has the overall responsibility for ensuring the quality and appropriateness of the ISP.

For the client, monitoring will ensure that:

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

Monitoring also identifies any gaps between individual client needs and existing resources, which is important for improved service development.

Each client's progress will be formally reviewed at regular intervals of at least six months. The case

manager will be responsible for coordinating the review of the Needs For Service Assessment and the ISP and its implementation. At this point, the extent and nature of unmet and met needs can represent one measure of outcome and can prompt decision making about requirements for further services.

The format of each review may differ from client to client, reflecting the individual needs of the client concerned. The views of others involved in providing services to the client should be sought in order to provide an accurate monitoring of programs and to assist in collaborative practice. However each review must involve the multi-disciplinary team and receive the endorsement of the DCS or their delegate.

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

### • *Continued Monitoring*

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

### • *Reassessment and/or revision of the ISP*

It may be appropriate to return to the earlier functions of the service delivery process. For instance, the client's needs may require reassessment, or the original goals may have proved to be inappropriate or irrelevant. This can be an appropriate point at which a client may change services within public mental health services, for instance from an inpatient of an Acute Psychiatric Unit to a client of a community mental health service, or from a client of a Mobile Support and Treatment (MST) service to a Psychogeriatric Assessment and Treatment service. In these situations, cases are not

closed because the clients are still receiving services from public mental health services.

Some clients will use a number of different services within the course of their illness.

- *Closure*

The client's service needs can be met appropriately by services outside public mental health services, and they no longer require to use public mental health services.

*Each client will have their individual service plan formally reviewed at least six monthly.*

## Closure

Whilst continuity of care is important, people who have experienced a mental illness will not necessarily need public mental health services for their entire lifetime. Some clients use these services during a single acute episode, or over several episodes of illness, and then make a full recovery. Others will appropriately move to the private system and have their treatment needs met by a private psychiatrist or a General Practitioner, or continue to make use of non-government disability support services, with no further involvement from public mental health services. Still others will prefer no involvement during times of wellbeing.

The decision to close a case should be made together with the client and other significant people in their life. It should be based on sound clinical judgement, made by the multidisciplinary treating team coordinated by the case manager, and endorsed by the Consultant Psychiatrist. Ease of re-access should be emphasised to the client and to carers.

A case is closed when the client no longer requires public mental health services, or the services are no longer appropriate. The case will not be closed until all involvement from public mental health services has

ceased, including monitoring of the effectiveness of transfer arrangements.

Formal case closure requires completion of an appropriate termination process which should include:

- Referral/s, as appropriate and with the client's consent, to other agencies such as a non-government disability support service, family support service, or a General Practitioner.
- Appropriate follow up after referral to ensure that duty of care requirements are met.
- A clear understanding between case manager and client about reasons for closure.
- Closure formalised in writing to the client.
- Informing carers and other service providers of closure, where appropriate.
- Informing the client, family and service providers, where appropriate, how to re-access the service if necessary in the future.

*When a client no longer receives public mental health services and appropriate follow-up has occurred the case will be closed.*

# Implementation

It has already been noted that many clinical staff and service managers have recognised the need to accord case management a central role in ensuring continuity of care for clients. Most community mental health services have taken steps towards provision of coordinated care based on case management, and introduced systems of service delivery similar to the *Client Services Model*. For staff of these services, the requirements of the policy presented in this document will build on and enhance their current practice.

To ensure comprehensive introduction of the system of coordinated care in public mental health services across the state, a staged approach will be used with the following elements:

## Regional Planning

The policy will be implemented in stages in each region as determined by negotiation and agreement between regional management and the Psychiatric Services Branch. This approach to implementation acknowledges the variation in case management practices across regions and will enable regions to design implementation around any needed changes. It also recognises that regions will be at different points in the development of integrated area mental health services, including provision of locally accessible acute beds, the availability of continuing care beds in the community through Community Care Units, and the establishment of Mobile Support and Treatment (MST) services.

Importantly, staged implementation will also provide a basis for both regional management and the Branch to monitor the resource implications of implementation in each region, and for regional management to review the distribution of resources across services.

## Staff Training

The Psychiatric Services Training and Development Unit (PSTDU) provides access to training for all clinical staff in the *Mental Health Act 1986*, negligence, consent and confidentiality.

## Use of the Client Services Model

A two day training program has been designed by the PSTDU to be delivered in all regions to targeted clinical staff and service managers. This program has already been piloted, and provides staff with a comprehensive understanding of the *Client Services Model* and its implications for their practice.

Additional training in case management skills will also be delivered by the PSTDU.

## Reception Skills

Training for reception staff in community-based services across the state will be provided by the PSTDU through the delivery of a one day program. This will focus on the reception phase in the *Client Services Model*.

## Advanced Case Management

Staff training sessions in advanced case management skills will be offered by the PSTDU.

## Information Sessions

Information sessions will be organised and delivered across all regions so that consumers, carers, non-government organisations, and staff of public mental health services not included in other training sessions will be fully informed about the content and operation of the *Client Services Model*.

This comprehensive introduction of the system of coordinated care is designed to ensure that all interested parties are familiar with its applicability, and that relevant staff have the understanding and skills needed for its implementation

# Performance Indicators

Use of the *Client Services Model* provides the basis for recording and analysing data on service activity on a regular basis, and for evaluating service performance.

Information on service activity includes the following basic data:

- The number of reception contacts.
- The number of duty contacts.
- The number of intake assessments.
- The number of clients who proceed to service provision.
- The number of active cases.
- The number of cases closed.

The collection and analysis of these data on a regular basis will enable identification of how the service is being used, and how resources are being utilised. Particular patterns of service activity can prompt further investigation. For instance, the proportion of clients who actually receive services may be low compared to the number who are seen at duty and receive intake assessments. This raises the question of whether the service is being accurately publicised, or whether it is serving as a 'catchall' because of the lack of alternative services in the area such as private psychiatrists or non-government counselling services. This information should be used to facilitate changes to service delivery as appropriate.

In addition to basic data on how the service is being used, information can also be generated on service performance. Performance evaluation requires that standards have been established, and data are available to measure the extent to which standards are being met. The *Client Services Model* sets a number of clear expectations regarding service delivery, and enables data to be collected that show whether these expectations are being followed.

Performance indicators in relation to service delivery will be:

- The proportion of clients who receive a comprehensive assessment.
- The proportion of clients who have a current Individualised Service Plan (ISP).
- The proportion of clients whose ISP are reviewed after six months.
- The proportion of clients who have a case manager.

Other qualitative indicators will include:

- The proportion of clients who have the same case manager over a six month period.
- The proportion of cases closed with all guidelines for case closure met.
- Needs outlined in ISP that were met.
- Needs outlined in ISP that were unmet.
- The proportion of active cases in which direct contact has not been made in the previous six months.

Local targets should be set annually by Area Service Managers, and will need to reflect national consumer outcome measures.



# Appendix 1: Clients of Public Mental Health Services

*Victoria's Mental Health Service: Framework For Service Delivery* identifies and describes the target groups for public mental health services as:

## Child, Adolescent and Family Mental Health Services

Services are targeted at children and adolescents with serious emotional disturbance. That is, young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to psychosocial development and/or where it leads to serious difficulties in the person's social or family environment.

Emotional disturbance in childhood and adolescence may present in a variety of ways. While symptoms may include impaired reality testing, hallucinations and suicidal behaviour. More often emotional disturbance in childhood and adolescence presents in other ways—hyperactivity, nightmares, depression, fearfulness, bed wetting, soiling, temper tantrums, stealing, poor impulse control, anti-social behaviour, obsessional behaviour, relationships problems, language problems, learning difficulties, refusal to go to school, unusual eating patterns and physical illness.

While many young people at some time in childhood will present with one or more of these behaviours or difficulties, usually children and adolescents are not considered to be emotionally disturbed unless a pattern of symptoms emerge which are inappropriate for that young person's age, state of development or circumstances.

The highest priority for child, adolescent and family mental health services are those young people with the most severe symptoms or who are in a high risk group. Some disorders more commonly emerge at particular developmental stages.

Children and adolescents in the following circumstances are more likely to be at risk of a serious mental disturbance:

- Victims of physical, sexual 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.
- Infants with attachment difficulties and where there are serious problems in parent/infant relationships.
- Those with developmental difficulties, learning difficulties and/or an intellectual disability.
- Those with chronic health problems and disabilities.
- Post trauma and post disaster victims.

It is recognised that 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 available in the community. Specialist mental health services operate as part of a broader network of services for children and young people and must develop and maintain linkages with these services.

## Adult Mental Health Services

Adult public mental health services will provide assessment, treatment and support services to people with serious mental illness and/or an associated significant level of psychosocial disability. This includes clients suffering from functional psychoses, both acute and persistent, severe mood or eating disorders, or those who present with situational crises which may lead to self-harm or inappropriate behaviour directed towards others. People with severe personality disorder whose behaviour places themselves or others at risk of harm are included in the target group.

Services will be organised to address the needs of persons primarily between the ages of 15 and 64 years, although age alone will not be a sufficient criterion to

exclude a person from service provision or to transfer them to other services such as aged care services. Similarly, the decision about which program will provide services to a young person will be based on established criteria that reflect client need.

### Aged Persons Mental Health Services

Services are provided primarily to people aged 65 years and over including:

- People with a long-standing mental illness who have grown older.
- People with functional illnesses such as depression and psychoses which have developed in later life; and
- People with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

People whose mental illness is of late onset or is characteristic of older patients should be treated as far as possible as part of the aged care system rather than as a part of general adult psychiatry which extends from 15 years of age. Aged person's mental health services, therefore, should operate with strong linkages with the broader network of health and community services for older persons.

Service provision to people who are mentally ill and who are over the age of 65 years becomes more complex as the effects of the ageing process becomes more prominent and clinical approaches differ according to the cause of the condition. Detection of age-related conditions is more likely to occur in a service which specialises in aged persons rather than in one which deals with people from 15 years of age. This also allows transition to the aged care service to be managed in a manner that is sensitive and oriented to the client's need at a time when the client can best adapt to that change, that is, in the absence of clinical needs. The use of age as a guideline acknowledges that people over the age of 65 years with mental

illness often have co-existing physical problems which needs attention from aged care services. This is particularly pertinent to the 'very old', that is those over 85 years who are more likely to suffer chronic illness, progressive disability, poorer recovery rates and physical frailty.

# Appendix 2: Legal Responsibility of Mental Health Professionals

These questions are often asked by health professionals about their legal liability in treating clients of the public mental health system.

Who is legally responsible for treatment administered to clients?

Each person who is involved in the treatment of a client is responsible for their actions and decisions in dealing with the client. If a treating professional, medical or non-medical, is being supervised by another person, then the supervisor will also be legally accountable for properly supervising the work of that person.

Case managers will be legally responsible for any clinical treatment they provide as well as for coordinating the system of care provided to a client.

Courts will assess whether an individual practitioner has behaved appropriately by considering whether or not the practitioner's actions or decisions were reasonable in that situation. The outcome of any court case where a client is injured will depend largely on the facts of the particular case, and what is reasonable in one situation may not necessarily be reasonable in another. It may depend on the circumstances in each case.

Is the doctor who recommends an involuntary client legally responsible for everything that happens after admission?

No. The medical practitioner is only responsible for the decision to recommend, and for treatment which they provide or authorise others to provide to the client. If other services/treatment are provided to the client, those services are the legal responsibility of the health professional providing them.

However, if non-medical treatment may affect the medical treatment, the medical practitioner must liaise with the other health professional to ensure that the client is not adversely affected by the combined effect of the treatments. The medical practitioner is responsible for any necessary alterations to the medical treatment, and the other health professional is responsible for necessary alterations in the non-medical treatment.

If a medical practitioner is supervising others in a treating team, the medical practitioner will have responsibilities as a supervisor as well as being responsible for their own treatment.

Who is legally responsible for treatment given to involuntary clients? Is this different for voluntary clients?

Each person involved in the treatment of both voluntary and involuntary clients is legally responsible for the treatment they provide, as described above. The status of a person under the Mental Health Act 1986 does not affect this.

Certain people specifically referred to in the Mental Health Act have extra responsibilities in dealing with clients—for example authorised psychiatrists appointed under the Act. Where the Act specifies that a decision must be made by the authorised psychiatrist, then the authorised psychiatrist (or a duly appointed delegate) will be held accountable for that decision, even if another person effectively made the decision. For example, a decision to make a community treatment order can only be made by an authorised psychiatrist, and if the decision is made by the authorised psychiatrist solely on the basis of (inaccurate) information provided by another health professional, the authorised psychiatrist may still be legally accountable for that decision.

Is the medical practitioner involved in the treatment of a client legally responsible for the decisions of other people treating the client?

The medical practitioner is only responsible for those decisions made by themselves and for any treatment they provided or authorised. Similarly, other health professionals will be responsible for the clinical decisions and care they provide for the client.

If the medical practitioner is also the client's authorised psychiatrist under the Act, the medical practitioner will also be legally accountable for all decisions which the Act specifies must be made by the authorised psychiatrist.

## Appendix 3: Sample Intake Assessment

Sample—Intake Assessment		
Assessment Areas	Date Completed	Comments
Presenting Problem		
Why is the Person Presenting Now?		
Risk Assessment		
Mental State Examination		
Is the Presenting Problem a Mental Health Problem?		
Psychiatric History		
Family/Living Situation		
Major Social or Psychological Stressors		
Physical Assessment		
Drug And Alcohol Use		
Special Characteristics of the Person Which Need to Be Taken into Account, Such as people from Non–English-Speaking Background (NESB), Disability		
Developmental Issues and Family Function		
Urgency of Intervention		
Preferences for Case Manager and Other Clinicians, in Terms of Gender, Ethnicity, Previous Contact, and Treatment Location		
Discussion of Client's Rights		
Outcome Of Intake Assessment		

**It may be appropriate to include additional screening measures such as a brief disability measure and/or a response difficulty checklist.**



# Appendix 4: Needs for Service Categories

These categories represent one way of ensuring a comprehensive and balanced approach to assessment. This approach emphasises paying careful attention to changing needs over time. Needs can arise due to impairment, disability and disadvantage. Interventions that minimise symptoms can diminish disability. Conversely interventions that limit disadvantage, such as provision of acceptable housing, can decrease stress and have a positive impact on symptom reduction. It is essential that people with mental illness have access to services that address clinical and lifestyle issues in an integrated and flexible way.

The process of needs assessment must occur in a way that satisfies requirements of duty of care. Urgent immediate needs must be identified and acted upon. Where this involves involuntary treatment, requirements of the *Mental Health Act 1986*, must be met.

The naming of the categories reflects the preference of clients for everyday language, and assists collaborative practice in the development of individual service plans. Information for clients and carers is being developed to assist them to understand the process of assessment, planning and review in order to facilitate active participation.

## Emotional and Mental Wellbeing

*The entire experience of mental illness and treatment has a major impact on emotional, mental and spiritual wellbeing. Acute symptoms are manifest in changes in thinking, reasoning, perception and mood. The negative symptoms related to major mental illness can significantly mar the range of emotional experience, often hindering purposeful and productive activity, and social and intimate relationships. Clients can experience anxiety, depression and related emotional difficulties regardless of their primary diagnosis.*

## Areas To Consider

- Mental status examination covering:
  - Appearance behaviour
  - Speech
  - Appetite
  - Sleep
  - Orientation
  - Memory
  - Impulse control
  - Insight
  - Judgement
  - Thought process
  - Perception
  - Mood
  - Substance use
- Psychiatric history
- Personality issues
- Personal history
- Medical examination to identify any physical factors affecting mental state:
  - History of injury or congenital problems
- Special attention for suicidality
- Impact of positive symptoms such as:
  - Intrusive thoughts
  - Mania
  - Hallucinations
- Impact of negative symptoms such as emotional blunting:
  - Absence of pleasure experiences
  - Volition
  - Cognitive difficulties
  - Related disability
- Impact of person's emotional and mental wellbeing on others close to them such as:
  - Child
  - Spouse
- Impact of other family member relationships on emotional wellbeing of person

## Dealing with Stress

*People who have experienced mental illness are often more vulnerable to stress in everyday life. This can arise with both negative and positive life experiences. People have a range of ways of coping with stress. There is a considerable literature addressing the value of assisting people with coping strategies that can lessen the likelihood of relapse or the severity of its impact.*

### Areas To Consider

- Personal strategies for dealing with symptoms and recognition of early warning signs.
- Capacity to identify more and less effective strategies for dealing with stress.
- Obvious stressors in the environment (practical and interpersonal).
- Buffering/supportive experiences.
- Attitudes to help seeking.
- Judgement and decision making.
- Balance of useful and problematic coping strategies such as alcohol use.
- Early life experiences contributing to stress such as unresolved trauma.

## Personal Response to Illness

*The experience of mental illness can have a major affect on how a person perceives themselves and their hopes and dreams for the future. Mental illness involves stigma in most cultures. The social and personal implications associated with being diagnosed as mentally ill are vast and the person's response to these can influence their recovery path. Poor self esteem and lack of confidence and social distress or anxiety can have a major impact on a person's hopeful/despairing outlook for the future.*

### Areas To Consider

- Confidence in, or confusion about, identity.
- Personal turmoil and distress related to illness.

- Grieving for loss of old self or dreams for the future
- Resolution of trauma related to illness and treatment experiences such as:
  - Embarrassing behaviour.
  - Loss of children.
  - Estrangement from loved ones.
  - links with this and any previous unresolved trauma.
- Level of hope.
  - Confidence.
- Self esteem in balance with level of distress.
  - Anxiety.
  - Sadness.
- Degree to which the client experiences control over their life.
- Availability of appropriate support.
- Strengths such as cognitive coping skills.
  - Humour.
  - Hopeful attitude.
  - Robust sense of self.
- Personal explanatory model of mental illness and its fit with the service culture and the family culture.

## Personal Safety and the Safety of Others

*Safety issues are of primary concern for clients, carers and service providers. Issues of the client's own safety and vulnerability in the community and the safety of others when there is a risk that the client can threaten others' safety are both crucial.*

### Areas To Consider

- Safety of client's physical and emotional environment.
- Risk and/or previous experience of physical or sexual abuse by others.
- Potentially high risk behaviour such as wandering in traffic.
  - Intentional self harm and/or suicidality.
  - Risk of violence towards others, especially family members or other carers.
  - Contingency plans.

- Physical safety and emotional security of children of parent with a mental illness.
- Personal level of autonomy vs dependency.

## Friendships/Social Relationships

*Social competence has been associated with better recovery from serious mental illness in longitudinal studies worldwide. Studies indicate that 40–45 per cent experience a social recovery in addition to the 25 per cent who have a full recovery. Studies identify relationships and particularly friendships as a most important area of need. Many people experience loneliness and difficulty being with others in a comfortable way.*

### Areas To Consider

- Size and quality of friendship network.
  - Level of enjoyment and satisfaction from relationships.
  - Value placed on peer relationships.
  - Levels of comfort or anxiety.
- Quality of intimate and sexual relationships.
- Practical barriers to friendship such as previous experience of trauma in relationships.
- Performance of social roles.
- Level of support in family relationships.

## Work/Leisure/Education

*Purposeful activity is constantly raised by consumer studies, as a highly valued goal. Employment and career options are frequently limited for people with mental illness because of the episodic nature of illness and recovery, and stress involved in maintaining fulltime employment and/or tertiary education. Leisure activities that are interest driven are important for maintaining a sense of purpose and individuality and enjoyment, regardless of work suitability or availability.*

### Areas To Consider

- Personal interests:
  - Motivation.

– Skills.

- Cognitive abilities such as:
  - Capacity for new learning and problem solving.
  - Concentration.
  - Memory.
  - Impact of current negative and positive symptoms on these factors.
- Likely opportunities for staged involvement in meaningful activities.
  - Previous or current work/leisure/education experiences.
  - The interplay between social and task issues.

## Daily Living Skills

*The ability to maintain independent living skills can influence the likely housing and social relationship options for people with a mental illness. Some clients are unable to use these skills for short periods during acute illness and need time limited support during a recovery period. Others continue to experience difficulty with performing household and community survival activities. Developing such skills may be very important to some people and a low priority for others. Some clients may experience great difficulty relearning these skills, even when motivated. The benefits of providing basic support versus assistance with skills (or both) must be considered in the light of the client's own goals and the likelihood of a positive outcome.*

### Areas To Consider

- Level of concern/distress about performance of daily living skills.
- Requirements of others dependent on the client for personal care and survival, such as:
  - Children.
  - Elderly relatives.
- Particular need for skills in current or preferred living environment.
- Availability of support options in the formal and informal network.

- Cognitive abilities, such as:
  - Capacity for new learning.
  - Concentration.
  - Memory.
- Social versus task issues.
- Impact on others caring for the client.

### Family's Response to Relative's Illness

*Family members and other carers can experience major grief, personal turmoil and disruption to family life when a close relative is mentally ill. Family members and the client need support in their relationships and timely information to adjust to the impact of the illness in each other's lives. Information about the service system and support organisations is crucial.*

### Areas To Consider

- Attitudes and explanatory models of illness.
- Cultural perspective on help seeking.
- Response to person with illness:
  - Tension levels in family relationships.
  - Need for and response to information about illness/treatment.
  - Guilt and blame issues for all family members.
- Resources and strengths of family unit or alternative caregivers.
  - Economic or health problems.
  - Degree of support experienced by member with a mental illness.
  - Degree of isolation or connectedness of family with community.
  - Special needs of children of mentally ill parents.

### Income

*People who experience mental illness are often severely economically disadvantaged for long periods of time. Lack of access to flexible options in the paid workforce results in poverty. Clients often have extra health care costs associated with their illness and available supported accommodation options frequently leave them*

*with minimal disposable income. Leisure pursuits and attempts at more independent living, necessary for personal recovery, are often inaccessible due to poverty.*

### Areas To Consider

- Financial requirements to meet lifestyle needs evident from other areas of need.
- Level of autonomy over finances for major issues.
  - Everyday living.
  - Potential for exploitation by others.
  - Potential sources of additional income.
  - Advocacy requirements re income security.
  - Problem spending for example on illicit drugs during manic episodes.
- Any coping strategies or contingency plans.

### Physical Health

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

### Areas To Consider

- Recency and outcome of general health review.
  - Attitude to health care.
  - Autonomy re access to services.
- Health information on risks such as those related to sexuality
  - Drug use
  - Preventative screening
  - Sensory
  - Nutrition
  - Mobility issues
  - Side effects of psychotropic and other medication
  - Risks to health in physical environment

- Drug dependency.
- Other major injury or illness such as head injury or diabetes.

## Housing

Evaluative studies of mental health programs worldwide have shown that stable and suitable housing with appropriate support is associated with improved outcomes for people with mental illness. Inappropriate living situations can significantly contribute to stress in the day to day life of people with a serious mental illness.

## Areas To Consider

- Availability of housing options that match the preference of client.
- Specific support needs influenced by:
  - Symptoms
  - Disability
  - Gender or cultural issues
- Income issues.
- Social issues that will affect living with others:
  - Family issues where living with family.

## Rights and Advocacy

Because of the level of social and economic disadvantage experienced by people with mental illness and community stigma, attention to rights and advocacy for active community participation are important for achieving improved outcomes. Self help and consumer advocacy groups and legal advocacy can assist individuals to overcome discrimination.

## Areas To Consider

- Information requirements about advocacy groups.
  - Rights in relation to mental health care.
  - Tenancy.
  - Health care.
  - Income security.
- Ability to understand rights, information about services and ability to self advocate.

- Choice about including a personal friend or advocate.
- Guardianship or administration requirements.



# Appendix 5: Sample Format for Needs Summary to Accompany Individual Service Plan

Name :

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Address:

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Date Completed:

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Participants and their role:

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Priority needs areas identified by:

**Client** (consider your own needs and your opinion about the needs of your family or other caregivers):

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**Friend, family member or advocate** (you are present by request from the person requiring services):

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**Family members and other caregivers** (consider your own needs and your opinion about those of your relative who requires services):\*

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**Workers** (specify name, role and service):

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The attached service plan will cover the following priority needs;

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The attached plan will not cover these priority needs;

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The reasons (in brief) for this are:

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**Notes**

Participants may wish to sign this summary and the Individual Service Plan based on the Need Summary.

*\* This type of summary would be appropriate where the client and family members agree to address issues together. In some instances the client may wish to have their needs addressed totally independently of the family. In such a case, family needs arising from their relative's illness should be addressed separately.*

## Appendix 6: Sample Case Closure

Formal case closure requires completion of an <i>appropriate</i> termination process. The following step by step process is a guideline only.			
Step	Action Taken	Outcome	Date Completed
Review of Case			
Consultation with treating team re case closure decision.			
Discussion with clients and carers re closure, procedure for re-access, and options after closure.			
Referrals to other service providers as appropriate, that is GP, accommodation services, non-government disability support services, and so on.			
Appropriate follow up after referral.			
Informing carers and other service providers of closure as appropriate.			
Closure formalised in writing to the client.			
Copy of case closure documentation placed on file.			

*When a client no longer receives the services of public mental health services and appropriate follow-up has occurred the case will be closed*