5 References and Suggested Reading:

The MHA 2000

The MHA 2000 Resource Guide

National Safety Priorities in Mental Health: A National Plan for Reducing Harm

National Standards for Mental Health Services 1996

Queensland's Mental Health Patient Safety Plan 2008 – 2013

Queensland Plan for Mental Health 2007 – 2017

Queensland Health Mental Health Standardised Suites of Clinical Documentation User Guides (2008, 2009)

6 Consultation

Key stakeholders (position and business area) who reviewed this version are:

Southern Qld Health Service Districts Mental Health Network – Working Party and consultation with district based staff.

7 Procedure Revision and Approval History

Version No	Modified by	Amendments authorised by	Approved by

8 Audit Strategy

Level of risk	
Audit strategy	Ongoing review by Southern Qld Health Service Districts Mental Health Network
Audit tool attached	Nil
Audit date	12 months from endorsement
Audit responsibility	Division of Mental Health Clinical Governance
Key Elements / Indicators / Outcomes	Improvement to patient care upon transfer

9 Appendices

APPENDIX A

Cultural considerations when transferring consumers

Cultural factors of consumer transfer between districts include the cultural sensitivity of the transfer/relocation of a consumer. Mental health staff in both the transferring and receiving services must obtain access to cultural expertise and advice.

Factors to be aware of:

- Locality/community

- Transferring service to liaise with Indigenous and culturally and linguistically diverse (CALD) mental health workers
  - Within their team and with the receiving district
- Social and emotional well being considerations
  - links to family, friends, elders

Locality/community – when Aboriginal and Torres Strait Islander people are local to a specific area/town/city/suburb cultural protocol states the mental health service will contact the local Aboriginal or Torres Strait Islander community. There are several ways of contacting and involving the Aboriginal and Torres Strait Islander community:

- Through family connection if the consumer has a relative within that particular community
- Consulting the Indigenous mental health worker in the receiving district.

If the consumer is going to a community that is not well known the Indigenous mental health worker must provide orientation for the consumer to the local Aboriginal and Torres Strait Islander community, with the consumer's consent.

Transferring service – It is the responsibility of the clinical team/case manager to notify the Indigenous mental health worker in the receiving district of the transfer of the consumer, whether to private or public follow up care. In the event that there is no mental health service in a community, notification to the Aboriginal Medical Service in that community is recommended. The Indigenous mental health worker from the transferring service needs to be involved / consulted in the transfer of all Indigenous consumers of mental health services.

In addition, the consumer's family, allied person, etc need to be notified of the transfer between districts, with the consumer's permission. Sometimes family exist in both the transferring district and the receiving district.
Consumers need to be orientated to the new district for services and links with Aboriginal and Torres Strait Islander organisations, such as the Aboriginal Medical services; cultural events, activities and meetings; other Queensland Health services and other Queensland Government services.

Social and emotional wellbeing - Following on from this, the consumer's social and emotional needs in the receiving service has to include: family and other relationships; cultural connections/support; other health concerns; housing; income; spirituality; stability of home environment; and, culturally appropriate psycho social interventions in the areas of: further education; diversional activities; fitness activities; clubs etc.

SKIPPEN, Tania

From: Kristi Geddes >
Sent: Tuesday, 23 September 2014 4:19 PM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation - interviews [ME-ME.FID2743997]
Attachments: 20140919 -letter to Minter Ellison re SGE KXMM 1084936.pdf; 20140919 - BAC - Attachments.pdf; Barrett - interview schedules.DOCX; Investigation and report framework.DOCX

Dear Tania and Beth,

We have received the **enclosed** response from WMHHS regarding the queries raised below (Tania this is what I had in hard copy for your review). We have also now received responses from all of the receiving agencies for the 6 complex patients under detailed review, some of which are quite large in volume, so they have been printed and included in the hard copy files we have here.

I **enclose** an updated witness schedule. All of the witnesses have now been advised of their scheduled time and advised to contact me as soon as possible if there are any issues. I have noted where we are aware of the support person they are bringing with them.

I also **enclose** an updated framework for investigation/report, which includes the flowcharts of governance and details of the further discussions I had with some key personnel from WMHHS.

Finally, I have had a discussion with Dr Sadler this afternoon regarding his changed interview time and he indicated that he thinks the Barrett Ward Record Book and PRIME incident reports would be relevant for our review. He explained that the ward was quite unsettled following the announcement and there were a number of incidents of self harm among the patients. Having not reviewed the clinical records myself, I just wanted to check whether either of you have come across any such incident reports and, if not, whether you consider these records for the transition period would be relevant for consideration in the report. If you think they will be, I will issue a further specific request to WMHHS for copies.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
www.minterellison.com

From: KOTZE, Beth
Sent: Wednesday 10 September 2014 11:34 am
To: Kristi Geddes
Cc: SKIPPEN, Tania
Subject: RE: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Dear Kristi
I have now touched base with Tania and this is what we've agreed:

1. Tania will use the 2 days when she comes up in September to finalise the review of the clinical files and to write up the clinical summaries that will be required for the report for all the patients in scope. These will be in the nature of brief over-view of each clinical scenario with particular comment on the documented transition plans.
2. In relation to the care coordinators can you please clarify:
    a. A number of the patients have 2 care coordinator names written beside them on the summary sheet – what does this mean? Was there a principal coordinator and a buddy? Or were there 2 care coordinators with clearly delineated roles? Some names have 'associate cc' written beside them – but in other cases there are 2 names and no difference noted.
    b. Is there a written statement of duties for the care coordinators?

c. Vanessa Clayworth's name isn't against any of the patients as care coordinator – what was the nature of her role? Was it formalised? If so can we please have a copy of the statement of duties?
d. What is 'business as usual' transition/discharge practice for the service as articulated in formal policies and procedures? If there is a service transition/discharge policy and procedure? Can we please have a copy?
e. Were there any specific policies/procedures/statement of duties put in place for the transition coordination for these particular patients? If so can we please have a copy?

3. Re the BAC review (?2008) can we please have any excerpt relevant to the topic of transition/discharge planning? Given the very long length of stay of the service one would expect that this would be a major field of activity even during 'business as usual', let alone in preparation for the closure. Did BAC routinely conduct followup of former patients? If so is a summary report available?
4. We will conduct the interviews together – so Tania will come up with me on Monday 13th October. The priorities for the interviews that day are the 2 medical officers (Clinical Director and Acting CD) and the care coordinators for the patients Looking through the sheet, it looks like all the patients in question had at least 2 care coordinators and some 3 but the same care coordinators were involved with more than 1 of the patients – by my calculations it looks like there are care coordinators involved with these patients? That would be 10 witnesses. I think we should try for 1 hour each for the medical interviews and 45 minutes for the care coordinators.
5. In relation to the ToR and particularly noting 3.1.4 which refers to the information available to clinicians and is quite specific about the care planning for the we definitely need to get information from the services to which they were referred. Can we obtain some general information about each one (what does the service provide etc) and if they have intake forms or assessments and initial care plans or equivalent? Tania and I can follow up with telephone calls to verify or clarify anything that we need to – so a key contact name and telephone number for each would be helpful.

In essence we are proposing that:

- the medical interviews and the file review and the information from the receiving services deal with the patient cohort overall (ToR 3.1.2;3.1.3,3.1.4)
- the medical interviews, the care coordinator interviews and the file reviews and the info from the receiving services deal with the specific cases identified as having poor outcome or complex transitions (ToR 3.1.4)

Can you clarify your interpretation of 3.1.2 – it could be read to mean that we would have to interview all the patients and their families to get the other side of the story – ie what did they think their needs were and how well were they met? It could also be limited to, based on the documented care planning and interviews, were the psychobiosocial needs of the patients and families identified comprehensively and comprehensively planned for?

Regards
Beth

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
NSW Ministry of Health
Direct Dial:
Address:
Email:
Website: www.health.nsw.gov.au/mhdao

NSW GOVERNMENT Health

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T.S 1179

From: Kristi Geddes
Sent: Tuesday, 9 September 2014 7:56 AM
To: KOTZE, Beth
Subject: Re: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Thanks Beth.

I will do my best to group the care coordinators according to patients, however there may be some overlap issues. Would you like to speak with RN Vanessa Clayworth or would you prefer leave that to Tania? Unfortunately, I do not have specific details of the extent of her involvement with any particular patients, I've just been advised that she played a key role in the transition planning and would therefore be someone we need to speak with.

In the interests of time, do you think it would be possible to obtain the information you require from the receiving agencies via information requests instead of interviews? If so, if you are able to provide me with a list of the specific information you require, I can attend to those requests and hopefully have the information for you upon your return from leave.

I look forward to hearing from you.

Kind regards,
sti.

Kristi Geddes
Senior Associate
Minter Ellison

On 8 Sep 2014, at 5:23 pm, "KOTZE, Beth" < > wrote:

> Thanks Kristi
> If at all possible we need to have the clinicians grouped by patients so that I do all the interviews associated with patient and Tania does all the interviews associated with patient
> If we start with the medical staff and the care coordinators for the whose files I reviewed that would be good – there were the and then
> I've had a look at the ToR again and I think it may be difficult to answer 3.1.2 and 3.1.3 in general and 3.1.4 in particular without talking to the agencies that received the referrals because appropriateness goes to the issue of the capacity and capability at the receiving end and the quality of the communication – I am wondering if some of these interviews could be done by telephone if the staff of these agencies are comfortable and willing to cooperate.
> What do you think?
> Beth

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
NSW Ministry of Health
Direct Dial:
Address:
Email:
Website: www.health.nsw.gov.au/mhdao
<image003.png>

From: Kristi Geddes [
Sent: Monday, 8 September 2014 11:40 AM

To: KOTZE, Beth
Subject: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Hi Beth,

I hope you had a lovely weekend after your trip up on Friday.

As discussed, I am currently arranging staff interviews for you on Monday, 13 October 2014. You had requested meeting with Dr Brennan, Dr Sadler and then each of the care coordinators for the [redacted] In total, that would be 9 witnesses.

I'm allowing an hour for each interview and based on your flight times last Friday, unfortunately that would only leave time for 6. I just wanted to check how you would therefore prefer I prioritise interviews. I have currently prioritised Dr Brennan and Dr Sadler and then at least one care co-ordinator for each patient. That leaves us with one spot left over.

I've been advised by WMHHS that RN Vanessa Clayworth, although not a care coordinator, played an integral role in transition planning.

I just wanted to check if perhaps I fill the last spot for that day with RN Clayworth and/or if you would prefer stay on an extra day and speak with all care coordinators for those complex patients?

Obviously, I will endeavour to instead arrange for Tania to interview the other care coordinators for those patients if you are not able to.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted] www.minterellison.com

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TJ 1181

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Sharon Kelly
Executive Director Mental Health and Specialised Services
Telephone:
Facsimile:
Email:

Ms Kristi Geddes
Minter Ellison Lawyers
PO Box 7844
Waterfront Place QLD 4001

By Email:

Dear Ms Geddes

Health Service Investigation – Barrett Adolescent Centre (Your Ref: SGE KXMM 1084936)

I refer to your letter to me dated 11 September 2014 regarding the investigation under Part 9 of the *Hospital and Health Boards Act 2011* (the Act) in relation to the closure of the Barrett Adolescent Centre (the Centre).

I understand that the investigators are seeking further information and/or documents to assist with their investigation, and have sought this information pursuant to section 194(2) of the Act.

With respect to the further information and/or documents requested, I advise as follows:

1. **Any document setting out a statement of duties or role description for care coordinators**

   Please find enclosed the following documents which set out the duties and roles of care coordinators (also known as case coordinators):

   Attachment 1 – Document titled 'Case Coordinator's Role' for the Centre – This document was located following a review of the Centre's records.

   Attachment 2 – Care Planning Package Tool Kit – This document describes the philosophy behind care planning, the roles and associated tasks, and forms part of a suite of tools and resources available to all care coordinators at The Park – Centre for Mental Health Treatment, Research and Education (The Park) via a shared electronic staff folder. This folder is accessible by way of an icon on the desktop of all clinical area computers.

Attachment 3 – Individual Care Plan Checklist: Adolescent - Care coordinators of the Centre utilised the Individual Care Plan Checklist to guide care planning at new episodes, standard and ad hoc review points, and at the end of an episode.

Attachment 4 – Extract from a document titled "The Barrett Adolescent Centre - Information for Teenagers" – This document was provided to each patient upon their admission to the Centre. The extract explains the role of the care coordinator on page 8.

Attachment 5 – Extract from a document titled "The Barrett Adolescent Centre – Information for Parents and Carers" – This document was provided to the parents of each patient upon their admission to the Centre. The extract also explains the role of the care coordinator on page 5.

The staff orientation program for all clinical staff includes a session on care planning and recovery, and introduces the statewide Consumer Integrated Mental Health Application (CIMHA) and expectations of CIMHA use across all clinical settings. A summary of the purpose and requirements of CIMHA is attached (Attachment 6). All care coordinators use CIMHA to provide shared access to their Consumer Care and Review Summaries which summarise the care being provided to each patient. They also use CIMHA to participate in Discharge Summaries issued by the patient's treating clinician.

2. **Information about the shared role of care coordinators, where patients were allocated more than one or also allocated an 'associated care coordinator', including whether there were clearly delineated roles between them**

As explained in the Care Planning Package Tool Kit at Attachment 2, each patient is allocated one care coordinator (CC), and ideally one care coordination associate (CCA). Patients are not allocated more than one CC. The role of the CCA is to proxy for the CC when that person is unavailable and to take on duties delegated by the CC. The CCA has the same authority as the CC, but cannot plan care, except in consultation with the CC, or, in the case of Enrolled Nurses, Rehabilitation Therapy Aides and discipline associates, under the supervision of a Registered Nurse or the relevant qualified discipline clinician.

The Care Planning Package Toolkit further defines the roles of CCs vis-à-vis CCAs.

3. **Information and/or documents about the 'business as usual' transition/discharge practice for the service, as articulated in formal policies and procedures, including any service transition/discharge policy or procedure**

Please find enclosed the following documents which describe the 'business as usual' transition/discharge practices for all mental health services, including the Centre:

Attachment 7 – Procedure titled "Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts" – This procedure was effective from 8 November 2010 until 12 May 2014 and describes the processes for managing the transfer of care of mental health consumers. Following the formation of Hospital and Health Services on 1 July 2012, this procedure continued to apply and be followed with all references to "Districts" being interpreted as referring to "Hospital and Health Services".

Attachment 8 – Procedure titled "Inter Hospital and Health Service Transition of Care of Mental Health Consumers from one Hospital and Health Service to another". This procedure replaced the procedure enclosed at Attachment 7, coming into effect on 13 May 2014 and reflects the transition to Hospital and Health Services.

Attachment 9 – Further extract from the document titled "The Barrett Adolescent Centre – Information for Parents and Carers". The extract provides a summary of discharge planning for patients admitted to the Centre.

Also, as referenced in Attachment 6, CIMHA is a key statewide tool supporting a range of clinical processes including discharge of patients and transition of care from one service to another.

4. **Any specific policies, procedures and/or statements of duties put in place for the transition coordination for these particular patients**

There were no specific policies, procedures or statements of duties put in place for the transition coordination of the adolescents who were inpatients or day patients of the Centre between 6 August 2013 (when the Centre's closure was announced) and January 2014 when the Centre was closed.

All staff involved in the transition of these patients were expected to employ 'business as usual' transition practice, policies and procedures for these patients as further outlined at point 3 above with the additional support offered by the West Moreton Management Committee, the Clinical Care Transition Panel and the Complex Care Review Panel.

5. **Further information about the role played by RN Vanessa Clayworth and Megan Hayes, OT, in the transition planning process, including whether specific roles were ever formalised and copies of any applicable written statements of duties and/or role descriptions developed**

<u>RN Vanessa Clayworth</u>

RN Vanessa Clayworth was appointed as the Acting Nurse Unit Manager of the Centre on 5 August 2013. In this role, Ms Clayworth was responsible for providing clinical advice in respect of the care of the Centre's patients, as well as overseeing the day-to-day management of the Centre.

Shortly following the announcement of the Centre's closure, it was recognised that extra clinical support would be required to assist with the transition of the affected patients' care from the Centre to alternative services.

Accordingly, in October 2013, Ms Clayworth was moved into the role of Acting Clinical Nurse Consultant. This allowed Ms Clayworth to focus on providing clinical advice on the care planning of the patients being transitioned and to provide clinical support to the Clinical Care Transition Panel and the Complex Care Review Panel.

The day-to-day management of the Centre which was formerly part of Ms Clayworth's role was assumed by Mr Alex Bryce, who was appointed as the Acting Nurse Unit Manager of the Centre on 14 October 2013.

The role description for the Nurse Unit Manager role at the Centre is attached as Attachment 10. The Clinical Nurse Consultant role comprises the clinical component of the Nurse Unit Manager role. Hence, when Ms Clayworth moved into the role of Acting Clinical Nurse Consultant as described above, she continued to perform the clinical component of her Nurse Unit Manager role while the non-clinical components were performed by Mr Bryce. We have been unable to locate a role description for a Clinical Nurse Consultant at the Centre, however we have enclosed a role description for a Clinical Nurse Consultant in our Medium Secure Unit to provide more clarity around the role of a Clinical Nurse Consultant (see Attachment 11). The Nurse Unit Manager role description (including the clinical component of it) continued to apply to the roles during the transition period and was not amended to reflect the specificities of this particular assignment.

The above changes in roles were communicated to staff by way of a staff communique issued on 3 October 2013, a copy of which is attached at Attachment 12.

Megan Hayes, Occupational Therapist

Ms Megan Hayes was a trusted and experienced allied health clinician at the Centre, employed as an Occupational Therapist HP3. Ms Hayes was asked to participate in the Clinical Care Transition Panel to provide an allied health perspective in light of her experience with the Centre and her level of knowledge surrounding the patients and their care. Ms Hayes' participation in the panel formed part of her usual role and, as such, her role description was not amended to reflect the specificities of this assignment.

6. **Whether BAC routinely conducted follow up with former patients and, if so, copies of any policies and/or procedures regarding the practice and summary reports of the outcomes from such follow up**

Given that patients discharged from the Centre were referred to other services to provide them with continued support in the community (which services assumed responsibility for their ongoing care), it was not the Centre's formal practice to routinely follow up with former patients. Accordingly, there are no policies and/or procedures regarding the practice nor summary reports of the outcomes from such follow up. I do however understand that the Centre's staff may have occasionally contacted patients post-discharge on an informal basis to check on their welfare.

7. **In relation to the BAC Review conducted in or around 2008, please provide any excerpt relevant to the topic of transition and/or discharge planning of patients**

With respect, I do not believe that this request falls within the scope of the Terms of Reference for this investigation.

I trust this information has been of assistance. Please let me know if you require any further information or explanation.

Yours sincerely

Sharon Kelly
Executive Director Mental Health and Specialised Services
West Moreton Hospital and Health Service
19 September 2014

Attachment 1

(Standards Appendix)

CASE COORDINATOR'S ROLE

(Barrett Adolescent Centre)

Case Coordinators are responsible for the effective management of a patient's care as directed by the Treatment Team. This is primarily a role of nursing staff. Case Coordinators are individually allocated prior to or on admission by the Nurse Practice Coordinator – Clinical Nurses Consultant in consultation with the Clinical Liaison Person and the nominated Case Coordinator. Selection is made with regard to clinical experience, caseload and specific skills or training. *(Related Standards NSMHS)*

Responsibilities of the Case Coordinator includes:

- Reporting to the Treatment Team at Case Conference. The Case Coordinator is to advise the team on the patient's recent and present well-being using identified problems (as per clinical history or Individual Treatment Plan). The Case Coordinator is to report on progress in relation to treatment objectives and the effectiveness of interventions. The Case Coordinator may present or document planned interventions for discussion and ratification by the team. Whenever unable to attend Case Conference, this clinical input is to be clearly documented for presentation. *(10.4, 10.5)*

- Being the primary liaison person with all other care agencies. These include other hospitals, Department of Families, schools, community clinics eg Child and Youth Mental Health Service, accommodation services, and other health practitioners involved in the patient's care. *(8.1.2, 8.1.3, 8.2, 8.3, 11.4.E.5, 11.4.E.4)*

- Attending all treatment plan review meetings (Intensive Case Workups) to assist the team in evaluating and developing treatment strategies for identified problems. *(11.5.1, 8.1.2, 8.1.3, 10.6)*

- Coordinating the implementation of treatment programs or strategies as directed by the team. This may include the monitoring of baselines, formulating behaviourally orientated interventions, assisting the adolescent with the use or mastery of various therapeutic strategies eg relaxation or behaviour rehearsal, and devising structured plans for other staff/carers to follow to promote a consistent approach to the patient's care. *(11.5, 11.4.E.5)*

- Building and maintaining a good therapeutic relationship with the patient and their carers. This enables the Case Coordinator to use cooperative and collaborate processes in addressing the patient's problems or day to day difficulties. The Case Coordinator engages the patient in participatory planning to facilitate the use of more effective problem-solving skills and coping strategies.

- Ensuring care is culturally appropriate if the patient is from a different cultural background. Liaising with the relevant cultural agencies, eg NESB cultural advisors, interpreter services, ATSI Liaison Officer and community support groups. Identifies sensitive cultural issues, bringing these to the attention of the team and taking appropriate action to address these. *(11.4.E.13, 7.1, 7.2, 7.3, 7.4)*

.../2

- Working in cooperation with the designated family therapist by arranging sessions with the families and participating as co-therapist. The Case Coordinator is largely responsible for dealing with family issues at times when problems arise. Acts as a support for family members and if required may facilitate attendance at other support agencies, eg Relationships Australia, ARAFMI. *(1.8, 3.2, 11.4.E.7)*

- Communicating on a regular basis with the parent or legal guardian to keep them well informed of the patient's well-being, treatment program and any changes that may occur. *(3.1, 3.2)*

- Accessing information from previous treatment teams or practitioners to assist in the assessment and treatment of the patient. This may include results of previous organic screening, psychometric testing and discharge summaries. *(8.2.4, 8.3.3)*

- Coordinating arrangements between staff, carers and other agencies concerning:

  - leaves on weekends and during holidays
  - financial needs, eg banking, pocket money
  - attending external appointments, eg medical consultations
  - school attendance or reintegration
  - respite care or alternative living arrangements

  (8.1.2, 8.1.3, 8.2.2, 8.2.3, 8.3, 11.4.E.8, 11.4.E.7, 11.4.E.5)

- Dealing with complex problems or care issues and arranging meetings with various individuals who may include the primary therapists, teacher, carers and the patient to develop treatment strategies. This may be a continuing process with meetings occurring throughout the assessment, treatment and discharge planning phases of the admission. *(11.4.D, 11.5)*

- Arranging a relief Case Coordinator prior to taking any leave of absence. Must give a comprehensive handover of the case. When not rostered on duty the Clinical Nurse will ensure continuity of care by attending to any of the above responsibilities as required. *(11.1.4, 11.4.D.6)*

CASE CO-ORDINATION

ACHS Standards

1.2.3 The health professional responsible for the care of the patient / consumer obtains informed consent for treatment.

1.2.4 Throughout their care, patients / consumers are informed of their rights and responsibilities.

1.2.5 The organisation encourages and provides opportunities for the patient / consumer to involve family, carers and friends in their care.

1.2.8 Planning for separation begins at first contact, is interdisciplinary and ensures a coordinated approach to separation and continuing management.

1.3.1 Appropriate professionals perform a comprehensive patient / consumer assessment that is coordinated and reduces unnecessary repetition.

1.4.1 A coordinated plan of care with goals is developed by the health care team in partnership with the patient / consumer and carer. The plan is developed in consultation with the patient / consumer and carer and addresses the relevant clinical, social, emotional and spiritual needs of the patient / consumer.

1.5.2 The health care team delivers care in partnership with the patient / consumer and carer and revises the plan of care and goals in response to patient / consumer progress.

1.5.3 Rights and needs of patients / consumers are considered and respected by all staff.

1.5.4 Care is coordinated to ensure continuity and to avoid duplication.

1.5.5 Education is provided by appropriate personnel to help the patient / consumer and carer understand the patient's / consumer's diagnosis, prognosis, treatment options, health promotion and illness prevention strategies.

1.6.1 Data relating to the goals and outcomes of patient's / consumer's care are analysed to provide information for care improvement.

1.6.2 Indicator data are collected and aggregated, and comparative analysis undertaken to improve patient / consumer care and management of services.

1.7.1 The patient / consumer and carer understand the plans and their responsibilities for continuing management. The plan is included in the clinical record of the patient / consumer.

1.8.1 Care is integrated between the organisation and other relevant services in the community to ensure the needs of the patient / consumer are met. The organisation provides information about the continuing management plan to the patient / consumer, carer, and relevant health care providers in a manner that maintains patient / consumer

confidentiality and privacy.

1.8.2 The organisation arranges access to other relevant community services in a timely manner, and ensures the patient / consumer is aware of the appropriate services before separation.

NHMS Standards

1.2 Consumers and their carers are provided with a written and verbal statement of their rights and responsibilities as soon as possible after entering the MHS.

1.3 The written and verbal statement of rights and responsibilities is provided in a way that is understandable to the consumer and their carers.

1.4 The statement of right includes the principles contained in the Australian Health Ministers *Mental Health Statement of Rights and Responsibilities* (1991) and the United Nations *General Assembly Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1992).

1.5 The right of the consumer not to have others involved in their care is recognised and upheld to the extent that it does not impose imminent serious risk to the consumer or other person(s).

1.6 Independent advocacy services and support persons are actively promoted by the MHS and consumers are made aware of their right to have and independent advocate or support person with them at any time during their involvement with the MHS.

1.8 The MHS provides consumers and their carers with information about available mental health services, mental disorders, mental health problems and available treatments and support services.

1.10 The MHS has an easily accessed, responsive and fair complaints procedure for consumers and carers and the MHS informs consumers and carers about this procedure.

3.1 The MHS has policies and procedures related to consumer and carer participation which are used to maximise their roles and involvement in the MHS

3.2 The MHS undertakes and supports a range of activities which maximise both consumer and carer participation in the service.

7.1 Staff of the MHS have knowledge of the social and cultural groups represented in the defined community and an understanding of those social and historical factors relevant to their current circumstances.

7.2 Information, relevant to care and continuing management, is given to the patient /

client and carers, and relevant health providers, and is included in the medical record of the patient / client.

7.3 The MHS delivers treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.

8.1.2 The consumer's transition between components of the MHS is facilitated by a designated staff member and a single individual care plan known to all involved.

8.1.3 There are regular meetings between staff of each of the MHS programs and sites in order to promote integration and continuity.

8.2.2 Mental health staff know about the range of other health resources available to the consumer and can provide information on how to access other relevant services.

8.2.3 The MHS supports the staff, consumers and carers in their involvement with other health service providers.

11.1.3 Mental health services are provided in a convenient and local manner and linked to the consumer's nominated primary care provider.

11.1.6 The MHS informs the defined community of its availability, range of services and the method for establishing contact.

11.2.6 An appropriately qualified and experienced mental health professional is available at all times to assist consumers to enter into mental health care.

11.2.7 The process of entry to the MHS minimises the need for duplication in assessment, care planning and care delivery.

11.2.8 The MHS ensures that a consumer and their carers are able to, from the time of their first contact with the MHS, identify and contact a single mental health professional responsible for coordinating their care.

11.3.3 The MHS has a procedure for appropriately following up people who decline to participate in an assessment.

11.3.5 The assessment process is comprehensive and, with the consumer's informed consent, includes the consumer's carers (including children), other service providers and other people nominated by the consumer.

11.3.9 There is opportunity for the assessment to be conducted in the preferred language of the consumer and their carers.

11.3.10 Staff are aware of, and sensitive to, cultural and language issues which may affect the assessment.

11.3.14 The MHS ensures that the assessment is continually reviewed throughout the consumer's contact with the service.

11.3.15 Staff of the MHS involved in providing assessment undergo specific training in assessment and receive supervision from a more experienced colleague.

11.3.17 All active consumers, whether voluntary or involuntary, are reviewed at least every three months. The review should be multidisciplinary, conducted with peers and more experienced colleagues and recorded in the individual clinical record.

11.3.18 A review of the consumer is additionally conducted when:

- The consumer declines treatment and support
- The consumer requests a review
- The consumer injures themselves or another person
- The consumer receives involuntary treatment
- There has been no contact between the consumer and the MHS for three months
- The consumer is going to exit the MHS
- Monitoring of consumer outcomes (satisfaction with the service, measure of quality of life, measure of functioning) indicates a sustained decline.

11.3.19 The MHS has a system for the routine monitoring of staff case loads in terms of number and mix of cases, frequency of contact and outcomes of care.

11.4.6 The MHS ensures access to a comprehensive range of treatment and support services which address physical, social, cultural, emotional, spiritual, gender and lifestyle aspects of the consumer.

11.4.7 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to dual diagnosis, other disability and consumers who are subject to the criminal justice system.

11.4.8 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in addressing the particular needs of people of ethnic backgrounds.

11.4.9 There is a current individual service plan for each consumer, which is constructed and regularly reviewed with the consumer and, with the consumer's informed consent, their carers and is available to them.

11.4.10 The MHS provides the least restrictive and least intrusive treatment and support possible in the environment and manner most helpful to, and most respectful to, the consumer.

11.4.11 The treatment and support provided by the MHS is developed collaboratively with the consumer and other persons nominated by the consumer.

11.4.A.1 The setting for the learning or the re-learning of self care activities is most familiar an/or the most appropriate for the generalisation of skills acquired.

11.4.A.2 Self care programs or interventions provide sufficient scope and balance so that

consumers develop or redevelop the necessary competence to meet their own everyday community living needs.

11.4.A.4 The MHS ensures that the consumer has access to an appropriate range of agencies, programs and/or interventions to meet their needs for leisure, recreation, education, training, work, accommodation and employment.

11.4.A.5 The MHS supports the consumer's access to education, leisure and recreation activities in the community.

11.4.A.6 The MHS provides access to, and/or support for consumers in employment and work.

11.4.A.7 The MHS supports the consumer's access to vocational training opportunities in appropriate community settings and facilities.

11.4.A.8 The MHS promotes access to vocational support systems which ensure the consumer's right to fair pay and conditions, award (or above) payment for work and opportunities for union membership.

11.4.A.9 The MHS supports the consumer's desire to participate in Further or Continuing Education.

11.4.A.10 The MHS provides or ensures that consumers have access to drop-in facilities for leisure and recreation as well as opportunities to participate in leisure and recreation activities individually and/or in groups.

11.4.A.11 The consumer has the opportunity to strengthen their valued relationships through the treatment and support effected by the MHS.

11.4.A.12 The MHS ensures that the consumer and their family have access to a range of family-centred approaches to treatment and support.

11.4.A.13 The MHS provides a range of treatments and support which maximise opportunities for the consumer to live independently in their own accommodation.

11.4 B Supported accommodation* is provided and/or supported in a manner which promotes choice, safety and maximum possible quality of life for the consumer.

11.4.B.2 Consumers and carers have the opportunity to be involved in the management and evaluation of the facility.

11.4.B.3 The accommodation program is fully integrated into other treatment and support programs.

11.4.B.4 Accommodation is clean, safe and reflects as much as possible the preferences of the consumers living there.

11.4.B.6 A range of treatment and support services is delivered to the consumers living in the

accommodation according to individual need.

11.4.B.7 Consumers living in the accommodation are offered maximum opportunity to participate in decision making with regard tot he degree of supervision in the facility, décor, visitors, potential residents and house rules.

11.4.B.8 There is a range of accommodation options available and consumers have the opportunity to choose and move between options if needed.

11.4.B.9 Where desired, consumers are accommodated in the proximity of their social and cultural supports.

11.4.B.11 The accommodation maximises opportunities for the consumer to exercise control over their personal space.

11.4.B.12 Wherever possible and appropriate, the cultural, language, gender and preferred lifestyle requirements of the consumer are met.

11.4.B.13 Consumers with physical disabilities have their needs met.

11.4.B.14 The MHS supports consumers in their own accommodation and supports accommodation providers in order to promote the criteria above.

11.4.B.15 The MHS provides treatment and support to consumers regardless of their type of accommodation.

11.4.B.16 The MHS does not refer a consumer to accommodation where he/she is likely to be exploited and/or abused.

11.4.C.3 The MHS obtains the informed consent of thee consumer prior to the administration of medication or use of other medical technologies such as Electro Convulsive Therapy.

11.4.C.4 The consumer and their carers are provided with understandable written and verbal information on the potential benefits, adverse effects, costs and choices with regard to the use of medication and other technologies.

11.4.C.11 The MHS promotes continuity of care by ensuring that, wherever possible, the views of the consumer and, with the consumer's informed consent, their carers and other relevant service providers are considered and documented prior to administration of new medication and/or other technologies.

11.4.D.6 The MHS promotes continuity of care for consumers referred outside the MHS for a particular therapy.

11.4.D.6 The MHS promotes continuity of care for consumers referred outside the MHS for a particular therapy.

11.4.E.5 The MHS ensures that there is continuity of care between inpatient and community

settings.

11.4.E.6 As soon as possible after admission, the MHS ensures that consumers receive an orientation to the ward environment, are informed of their rights in a way that is understood by the consumer and are able to access appropriate advocates.

11.4.E.7 The MHS assists in minimising the impact of admission on the consumer's family and significant others.

11.4.E.8 The MHS ensure that the consumer's visitors are encouraged.

11.4.E.12 The MHS, where appropriate, enables consumers to participate in their usual religious and/or cultural practices during inpatient care.

11.4.E.13 Consumers and their carers have the opportunity to communicate in their preferred language.

11.5.0 Consumers are assisted to plan for their exit from the MHS to ensure that ongoing follow-up is available if required.

11.5.2 The exit plan is reviewed in collaboration with the consumer and, with the consumer's informed consent, their carers at each contact and as part of each review of the individual care plan.

11.5.3 The exit plan is made available to consumers and, with the consumer's informed consent, their carers and other nominated service providers.

11.5.4 The consumer and their carers are provided with understandable information on the range of relevant services and supports available in the community.

11.5.5 A process exists for the earliest appropriate involvement of the consumer's nominated service provider.

11.5.6 The MHS ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow-up are satisfactory to the consumer, their carers and other service provider prior to exiting the MHS.

11.6.0 The MHS assists consumer to exit the service and ensures re-entry according to the consumer's needs.

11.6.1 Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

11.6.2 The MHS ensures that the consumer, their carers and other service providers and agencies involved in follow-up are aware of how to gain entry to the MHS at a later date.

11.6.3 The MHS ensures that the consumer, their carers and other agencies involved in follow-up, can identify an individual in the MHS, by name or title, who has

knowledge of the most recent episode of treatment and/or support.

11.6.4 The MHS attempts to re-engage with consumers who do not keep the planned follow-up arrangements.

11.6.5 The MHS assists consumers, carers and other agencies involved in follow-up to identify the early warning signs which indicate the MHS should be contacted.

Attachment 2

Queensland Government
West Moreton Hospital and Health Service
Mental Health and Specialised Services
The Park – Centre for Mental Health

Care Planning Package

Tool Kit

Adult Services

Version 3 August 2013

Contents

Care Coordination Framework

Care Coordination is a pivotal aspect of mental health service delivery that reflects supports and nurtures the embedding and growth of the principles of consumer and carer participation. It involves identifying the range of an individual consumer's needs and monitors progress towards meeting those needs in consultation with the consumer, their carer/s and with other health care resources nominated by the consumer.

Care Coordination and Care Planning are intimately linked. Whilst it is the role of the Care Coordinator (CC) to ensure that planned care is implemented, the role of developing the Individual Care Plan (ICP) and evaluating the care outcomes is the role of the multidisciplinary team.

The key principles of Care Coordination include:

- Individualised care
- right of consumers to comprehensive and appropriate care
- consumer participation in all aspects of care
- best practice
- accountability
- efficient and coordinated care;
- evaluation of care outcomes
- continuity of care

The Care Coordination model will be flexible and responsive to the needs of consumers and carers. It will utilise a joint planning process between consumers, carers and Care Coordination in the development of ICP's.

The ICP will be in an 'easy to read' format and available to the consumer and carer. Collaborative links will be developed with other health providers and strategies in the ICP will reflect a coordinated approach from all those nominated by the consumer as health resources.

CC's will be allocated to all consumers and will act to ensure that the treatments and care prescribed by the multidisciplinary team are implemented by the appropriate clinicians and/or agencies.

PROCEDURE

CC's can be allocated from the Medical, Nursing and Allied Health disciplines, as can Care Coordination Associates (CCA). Enrolled Nurses (EN) and Enrolled Nurse Advanced Practitioner (ENAP), may be allocated to the role of Care Coordinator and/or Care Coordination Associates, with appropriate support and mentoring from senior clinicians.

Ideally, there will be a CC *and* a CCA allocated to each consumer. The role of the CCA is to proxy for the CC when that person is unavailable and to take on duties delegated by the CC. The CCA has the same authority as the CC, but cannot plan care, except in consultation with the CC, or, in the case of Enrolled Nurses (EN's), Rehabilitation Therapy Aides (RTA's) and discipline associates, under the supervision of a RN or the relevant qualified discipline clinician.

One CC for each consumer will be drawn from the nursing service to maximise the availability of CC presence on the ward/residence. As a general rule, no staff member who works predominantly on the night shift will act either as a CC or CCA. However, where it is clinically useful to utilise a night shift worker as an associate, then this practice is acceptable.

In allocating CC's, consideration should be given to consumer need, staff skills and workload. However, all clinical staff must accept an active role within the Care Coordination framework.

Where possible, the consumer should have the opportunity to choose his or her CC and processes should be implemented to facilitate this at the local level. Consumers have the right to request a review of their CC allocation at any time.

On admission to the service or ward/residence area, a CC (and CCA where possible) will be allocated to the new consumer by the RN in charge. At the next Multidisciplinary Team Meeting, the CC and CCA positions should be ratified or alternative CC's should be nominated.

In ward/residence areas where admissions are planned, the multidisciplinary team will nominate the CC and CCA in advance of the admission. The nominated CC should make contact with the referring Client District agency to initiate the assessment and care planning priorities for the consumer.

Allocation Nurse

The Care Coordination approach is complemented by the allocation of allocation nurses to each consumer on a shift-by-shift basis. The nurse in charge of the ward/residence should facilitate this.

Ideally, the nursing staff who are CC's or CCA's will assume this role for those consumers on each shift. This enhances the notion of establishing a single point of accountability for the provision of care for consumers. The nursing staff allocation list should be displayed in a prominent area of the ward/residence for the consumers' information and updated each shift by the nurse in charge.

Reporting Relationship

The CC plays an active role in developing and monitoring a consumer's treatment plan, as well as liaising with other staff to ensure that treatments that have been prescribed by the multidisciplinary team are implemented in a timely manner.

The responsibilities of the CC are to participate in the development of an ICP; to ensure that appropriate documentation occurs; and to ensure that the plan is implemented and reviewed on a regular basis.

It is the responsibility of the staff designated in the plan to fulfil their respective roles and commitments to the consumer's care, with the CC acting to advise each clinician or service of their role in the consumer's treatment and to work directly with the consumer to meet his or her needs in accordance with the ICP, as appropriate.

The ICP is developed in conjunction with the multidisciplinary team and the consumer. The CC is a member of the multidisciplinary team and should, wherever possible, be present at Multidisciplinary Team Meetings when the ICP is reviewed. Where this is not possible, the CCA (or another staff member) should be properly briefed to proxy for the CC at the meeting.

Care Coordination – ICP Development

Within 72 hours of admission, the CC must develop an interim ICP that addresses the issues that have led to the consumer being placed in the ward/residence and initiate an Exit Plan. The interim ICP should address the consumer's immediate presenting problems, with a focus on safety. Each clinican may determine any additional requirements for the interim ICP.

The Exit Plan should begin gathering information regarding such things as: the consumer's preferred GP or psychiatrist; community supports and services that may be required; and an evaluation-of-care methodology that suits the consumer. The plans should be developed in consultation with the consumer. The CC should take this opportunity to understand and document the consumer's expectations of his or her treatment. The consumer's written consent to the involvement of family members in care planning should also be sought (see the section on *Carer participation and sharing information with carer*, page 23)

At the first meeting of the multidisciplinary team, a comprehensive review of the consumer's clinical presentation should occur, and the allocation of the CC and CCA should be ratified by the team. The multidisciplinary team members are to review the interim ICP and begin planning multidimensional care for the consumer that is focused toward community placement, and that is cognisant of the consumer's expectations.

The CC is to ensure that assessment of the consumer occurs to assist in planning and measurement of outcomes. The assessment and screening tools can include, but are not limited to, the following in the Care Planning Package:

- Outcome Measures (HoNOS, HoNOSCA, Life Skills Profile, Mental Health Inventory and other tools as outlined in the Queensland Health Outcomes Protocol)
- Risk Assessment Profiles on Aggression, Self-Harm and Absconding
- Consumer Participation Plan where appropriate

Clinical areas/teams may include other assessment and screening tools as required by their consumer population or individual consumer's needs.

Using the results of assessments, the CC will construct an ICP in consultation with the consumer and family members (where appropriate). All the above mentioned tools also form part of the care plan (e.g. the risk management plan attached to the Risk Assessment Profiles). Where the consumer dissents from the framework, attempts should be made to encourage the consumer to engage in the proposed plan. If this is not possible, then attempts should be made to negotiate an approximation of the proposed framework that is satisfactory to the consumer.

The ICP is a working document that is regularly reviewed and updated at least every 91 days in the context of a Multidisciplinary Team Meeting. The plan and the interventions that are attempted are subject to ongoing evaluation. Non-effective interventions should not be continued for extended periods of time. The plan should evolve. All attempted strategies and subsequent outcomes should be documented in the *Progress of Care* section of the ICP to ensure continuity of care and appropriate tracking of clinical outcomes.

A weekly review of consumer care from an ICP perspective should be documented in the clinical record by the CC to ensure effective clinical communication and review. *All* clinical entries should be made in the context of the ICP, usually either to flag interventions that have been made that have implications for an identified consumer issue, or to highlight the need for intervention in a new issue.

Review Process

Each clinical area should identify a responsible person to coordinate ICP reviews with the multidisciplinary teams and the CC's. Adequate notice must be given to the responsible CC, so that arrangements can be made to attend the Multidisciplinary Team Meeting or to brief the CCA or a proxy.

The need for emergent review of consumer treatment on occasions is inevitable. Attempts should be made, by the person convening the meeting to confer with the CC, even if he or she cannot attend the

meeting. In any case, the outcomes of emergent discussions should be clearly documented in the clinical record and should be flagged for the attention of the CC.

The emphasis in the above approach is upon ensuring the regular detailed review of all consumers and the effective flow of communication that recognises and values the role of the CC. Individual CC's will play an important role in ensuring that updated information is available at the relevant team review and that relevant amendments are documented in the ICP.

Evaluation of ICP's and Care Coordination Processes

Evaluation of ICP functionality and Care Coordination processes should be programmed at three levels:

1. Regular communication between the CC and the consumer to determine level of fit between consumer expectation and planned outcomes. Issues highlighted by such discussion should be conveyed to the multidisciplinary team.
2. During multidisciplinary team meetings. Particular attention should be paid to issues that have been standing for longer than three months (unless an extended timeframe has been anticipated during the development of the ICP).
3. Operational issues arising from care coordination should be documented and forwarded to the relevant Work Improvement Group (WIG) for resolution.

LEGAL/ETHICAL ISSUES

In terms of ultimate medico-legal accountability, the Consultant Psychiatrist retains this responsibility and the CC is responsible to the Consultant Psychiatrist with regard to care planning issues.

About the Care Planning Package

Background

The care planning package at The Park – Centre for Mental Health has evolved and adapted to provide recovery-oriented individualised care, whilst meeting local requirements and national standards for documentation and safety.

The care planning tools used at The Park have been audited every six months since 2003, to gather information on how the tools are used, quality of care plans, and integration of tools and measures. As a result of longitudinal audit information, consumer and clinician feedback, the changing clinical scene and documenting practices (eg computer systems for recording information), the new care planning package has been developed to enhance the way in which we plan and deliver care.

Using the Strengths model in care planning

The recovery principles have guided clinical practice and service planning at The Park. Changing practices towards consumer focussed care has involved a considerable change in work practices, attitudes and culture. These initial steps have laid the foundations for a strengths-based model of care.

The Strengths model is a way of viewing the people we work with, providing a focus on the positive aspects of a person, rather than just deficits or pathology. This model fits well with the recovery principles. The table below outlines the principles of the Strengths Model:

Six Principles of the Strengths Model - Rapp and Wintersteen (1989)

- The focus is on individual strengths rather than pathology
- The care coordinator / client relationship is primary and essential
- Interventions are based on the principle of client self-determination
- Assertive outreach is the preferred mode of intervention
- Long-term psychiatric consumers can continue to learn, grow, and change and can be assisted to do so
- Resource acquisition goes beyond traditional mental health services and actively mobilises the resources of the entire community

The Strengths model has been used and researched successfully in community mental health settings and is becoming accepted practice in many inpatient settings across the world. At The Park, the Strengths model can guide our care planning practices to ensure that consumer's strengths become the driving force for goal setting and working towards recovery.

For more information about the Strengths model and care planning, refer to the Resources section (page 24).

Computers and care planning

Completing care plans and associated information electronically is increasingly a requirement of mental health services. Electronic care planning has advantages in terms of time taken to review and update care planning tools, and sharing information within mental health services.

CIMHA is a consumer-centric clinical information system designed to support mental health clinicians in the provision of safer quality mental health services. CIMHA is used to record and access clinical information on consumers that is essential to care planning. In particular, care planning requires the use of CIMHA for:

- Inputting and reporting on outcome measures
- Recording Mental Health Act 2000 status, forms and requirements
- Recording 'alerts' and risk information
- Sharing information within the mental health network and updating care coordinators through clinical notes, messages, etc.

All clinicians should receive training and orientation to CIMHA, and be able to use the application as part of your day-to-day clinical work. CIMHA recognises care coordinators (or Primary Service Providers, as they are designated in the system), which means that care coordinators can quickly access the consumers they are allocated, and other clinicians can identify who they need to contact to share information on a consumer.

Key Care Planning information should be uploaded on to CIMHA for these reasons. Documents to be uploaded include the Individual Care Plan and any other important clinical information that may be pertinent to the consumer's overall treatment and care.

For more information on the use of CIMHA, please talk to your supervisor, contact the district ***Mental Health Information Systems Coordinator (MHISC),*** or access the online fact sheets and tutorials at http://qheps.health.qld.gov.au/mentalhealth/cimha/resources.htm

Guidelines for Electronic Use of Care Planning Documents

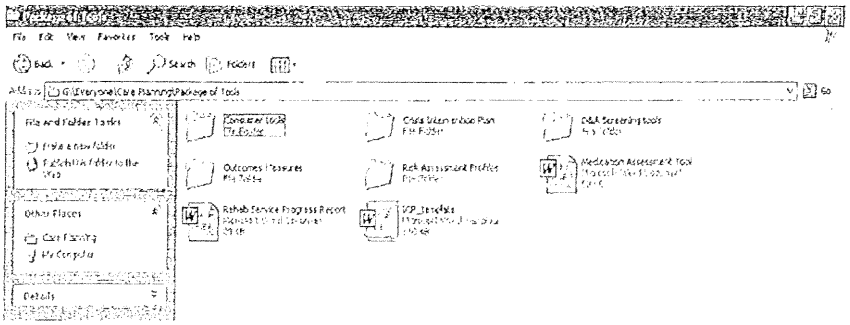
The Individual Care Plan is designed to be used as an electronic tool, to improve ease of completion and make reviews more efficient. Using care plans electronically does pose some considerations in relation to:

- Confidentiality;
- currency of documents;
- version control (e.g. making sure the right version is accessible, and that old versions are deleted); and
- Access (e.g. ensuring that care plans are saved to a location accessible to those who need it).

The following guidelines and conventions are provided to address these issues and make electronic care planning user-friendly for all clinical teams.

Accessing the care planning tools electronically

All care planning tools used for adult consumers across the facility are available at G:\Care Planning\Package of tools. You will see in this folder the following screen:



Separate folders contain the tools for consumer tools, crisis intervention plan, risk assessments, drug & alcohol screening, and outcome measures for printing (e.g. MHI). The ICP template is in a 'word template' form (easy to identify by the yellow top on the icon).

Completing an ICP electronically

Once the ICP template form is opened, it becomes a new document to be saved by the user. The template form cannot be saved over; this will hopefully reduce the chance of people accidentally saving care plans to G: drive.

The ICP template has form fields (grey areas) to indicate where information is required. By clicking with the mouse cursor on these grey areas, you can see whether the field is for text, a drop-down menu, or tick box. You can also use the tab or arrow keys to move from one field to the next. Tick boxes can be completed either using a mouse click, or the spacebar key. For some fields, an explanation of what is required will appear in the bottom left of the screen, just under the toolbar. This may help you to know what to put in that field.

The easiest way to find out how to use the form is to have a go! While you are still able to complete the ICP in hardcopy by printing out the template form, it does mean that you won't be able to view the drop-down menus and other prompts that are on the electronic version.

Saving Your ICP

Once you have completed the ICP, or if you wish to save what you have done so far, go to 'File' and the 'Save As'. You will need to change the document name (it will probably have "Date of Completion" as the document name). The recommended convention for naming your care planning document is:

Consumer's Surname_Consumer initial_Year(XX)Month(xx)

Some examples of this convention are:

Frankston_B_0703.doc	Indicates an ICP for B. Frankston completed in March 2007
Henderson_W_0710.doc	Indicates an ICP for W. Henderson completed in October 2007.

The reason for this convention is that it will save documents in alphabetical (by surname) and chronological (by the reverse date) order.

All clinical areas should have their own folders which can only be accessed by clinical staff from that area. Within these folders there may be individual consumer folders. The current ICP document should be saved to the consumer's folder. If you are unsure how to access these folders, please talk to your CNC or NUM.

It is very important that no consumer information is saved to G:\Everyone or to G:\Care Planning. These folders can be viewed by anyone at The Park, and saving information here is a breach of privacy and confidentiality. Please double-check the save destination (where you are saving the document to) before clicking on the 'save' button.

Uploading Care Planning documents to CIMHA

Once the ICP has been signed off by the Clinical Team, it should be uploaded to CIMHA. This can be done by scanning the documents, emailing them to yourself and saving them on a secure network folder.

Alternatively, select "Cute PDF" as the printer for the document and save on a secure network folder. From here the document can be uploaded as an attachment to CIMHA by opening the consumer record, selecting the clinical note type (Case Review Summary), adding the Attachment Summary Template and loading the template. Finally, complete the Summary details and attach the PDF document as per normal.

The Importance of hardcopy

When your ICP has been completed, it should be printed out, signed, presented to the clinical team, and filed in hardcopy in the clinical file. As we continue to work with paper-based recording systems, it is very important that these records are current and complete. A hardcopy in the clinical file may also be more accessible for quick review by other staff working with the consumer.

Reviewing your ICP & saving your review

When the review for the consumer you care coordinate is coming near, you can open the saved ICP electronically in Microsoft Word, and make any necessary changes quite easily. The bulk of information will already be there. It is important to still go through each of the areas to check that the details are updated. The 'Progress of Care' section at the end of the ICP gives the opportunity to record any goals that have been achieved.

Once you have completed your review, go to the File menu and click 'Save As'. Change the date on the document name before saving.

Once the reviewed ICP has been approved by the clinical team, the outdated ICP can be deleted from the electronic folder. ***Only current ICPs should be available on the clinical area folders, to avoid error in accessing outdated documents.*** Remember to upload the most recent versions of your ICP to CIMHA after sign off.

Accessing ICPs

Individual Care Plans can be accessed electronically through the clinical area's folder. If you are unsure how to access these folders, please talk to your CNC or NUM. Your work colleagues may also be able to orientate you to the clinical area folder and consumer folders.

Other considerations

Most documents in the care planning package are able to be completed electronically. Opportunities to develop your computer skills, through practice, attending training sessions, or picking up tips from your colleagues can help ensure that you feel confident and competent to complete care plans using computers.

The Care Planning Package Checklist

The Care Planning Package Checklist provides care coordinators and clinical team members with a quick reference of the tools that need to be completed for the care planning review, as well as the dates of previous reviews. A new checklist should be completed each care plan review.

The best way to complete the checklist is to print it and complete it manually as each tool is reviewed or revisited. The checklist provides a quick guideline for completion at the top of the page (see *Appendix A*, page 30)

There is space provided to include the risk screen rating for each review, and additional tools that the specific clinical area may use (refer to section *Other Assessment/clinical area tools* on page 28).

Reviewing or revisiting?

Care coordinators and consumers may sometimes feel that they are completing tools unnecessarily, when the information or scores haven't changed in the three month period. For some forms, it may be acceptable to re-visit the information to check that it is still accurate, without having to complete a full new form. Other tools have a standard or legal requirement to be completed every three months. Tools which are required to be *completely reviewed* at least every three months are:

- Outcome measures (HoNOS, LSP, MHI)
- Risk Screen Tool
- Involuntary Patient Summary
- Individual Care Plan
- Clinical chart audit is to be completed each 3 monthly review.

Tools that can be *revisited*, and signed off if no change is required, include:

- Consumer participation plan (check with the consumer if anything is different)
- Strengths assessment tool (this should be a 'living' document and added to as new strengths are discovered; however a new form doesn't have to be completed unless there has been significant changes, the consumer wants to start a new form, or the current form has become difficult to read. Each form has provision for signing a number of reviews).
- Drug Check, Audit & RTCQ

The Individual Care Plan & Recovery and Relapse Prevention Plan

The Individual Care Plan (ICP) and Recovery & Relapse Prevention Plan (RRPP) are the documents which bring all the assessments and information together and outline the goals for the consumer to work towards recovery. The ICP has a strengths focus, and aims to highlight the consumer's goals as well as the clinical issues. It aims to be a living document that is used to direct care and clinical decision making. For a completed example of the ICP, see *Appendix B*, pg 31.

Orientation to the ICP

The first page of the ICP includes identifying data, a consumer profile, alerts, review dates, and consumer involvement. All parts of this front page are to be completed. The 'Summary of Presenting symptoms' box is a chance to document briefly the main presenting issues and clinical concerns of the past 3 months only.

The following pages of the care plan have been divided into sections that relate to the categories of the Strengths Assessment (see information below). These categories are:

- Maintaining mental health
- Physical health, nutrition & ADLs (Weight, diet, physical comorbidities, self care & hygiene)
- Substance misuse
- Daily living situation/Financial/Vocational/Educational
- Social Supports & spirituality
- Leisure/Recreational

Each of these categories have a page devoted them, outlining the issues, assessment scores, goals and strategies, and progress of care. Here are some of the features of each category:

Substance Misuse: Drugs, Tobacco, Alcohol & Other Harmful Substances.

☒ *Drug Check & Audit* Completed on CIMHA Substance Misuse Problem identified	Date: 1/08/2013 ☒ Yes ☐ No		☒ *Readiness to Change Questionnaire* Completed/Reviewed ☒ *Substance Cessation Pathway* Completed	Date: 1/08/13 Date: 1/08/13	
Consumer's Goal Statement: I want to stop smoking forever			Summary of Current Issues: Was a heavy smoker (40 a day) but has been successfully using Inhaler & patches to cease smoking. Occasional drug use when on leave.		
HoNOS Scores	3	3	LSP Scores	6	2

Area to consider: Motivational Interviewing, AEQDs Support, MAISE Program, Psycho-education Programs
Refer to Drug Check & Audit, Readiness to Change model, Do A Pathway

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible (including Clinician, Carers, NGO's etc)	Review Date
Start decreasing use of Nicotine Replacement Therapies.	Reduce daily use of Inhaler. Continue to wear HRT patches.	Encourage use of Inhaler at PRH only.	Nursing staff	1/10/13
Routine UDS to be completed when return from overnight leave as per LCT conditions	I will not use drugs while on leave & cooperate with UDS on return	Administer UDS when consumer returns from leave.	Nursing staff	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. education programs, nicotine replacement strategies etc

Strategy	Did it work? Provide details	Date Attempted/Implemented
Attended MAISE rehabilitation program	Helped Mike understand his recreational drug use, Mike has avoided situations likely to lead to drug use while on LCT.	April 2013

Category heading:

This gives the names and brief description of the category.

Data relevant to this category:

Some categories have a section at the top of the page that allows you to outline information and assessments relevant to that category. This provides a quick reference for some important data.

Consumer's Goal Statement:

This is the consumer's goal for this category (if the consumer has one).

- The goal statement may come directly from the aspirations column in the Strengths Assessment.
- It should be written using the consumer's own words as much as possible, and specified as precisely as the person understands it.

The consumer's goal is not to be debated, but rather accepted and further explored. It may or may not be aligned with the clinical team's views. It is important for clinicians to remember that acknowledging consumer's goals is an important motivating factor and may provide a driving force for implementing strategies that are agreed upon by both the consumer and the clinical team.

Summary of Current Issues:

This box allows clinicians to outline the current concerns of the clinical team. This may include "problems" or "deficits", barriers to treatment, risk factors, and other influencing factors the care.

Outcome measure Scores:

This greyed row of boxes allows clinicians to record the outcome measures scores relevant to this particular category. This outlines the HoNOS and LSP scores that are relevant.

For instance, in the category "Daily Living Situation/Financial/Vocational/Educational, there are two HoNOS items (Item 11 and 12) and two LSP items (Item 13 and 16) that are relevant to that category. There is a blank box next to each item number for the clinician to insert the score. Each category has a **footnote** that describes the items outlined on that page. The use of the HoNOS and LSP scores in each category helps to link the outcome measures with the treatment strategies in the care plan. Items of the HoNOS that are clinically significant (ie a score of 3 or 4) should have relevant strategies for addressing these problems outlined in the care plan.

'Areas to Consider' and 'Refer to':
Under the outcome measures scores, there is a box which can assist care coordinators when developing care plan strategies. "Areas to consider" gives care coordinators a list of ideas for treatment and recovery strategies relevant to that category. "Refer to" gives a list of assessments or information sources that provide information relevant to that category.

The planning table:
The planning table details the *strategies, consumer actions, support role/treatments, responsible team members* and *review dates* required for the care plan, relevant to that category. Strategies may be seen as then short-term, "small-step" goals towards achieving the overarching recovery goals for the consumer, and for addressing the main clinical concerns. See the information on pages 14-15 about goal setting and developing strategies.

The *"Consumer Actions"* column refers to the tasks or techniques that the consumer plans to undertake to meet the strategy.

The *"Support Role/Treatments"* column outlines the tasks or techniques that the clinicians, carers and others plan to undertake to meet that strategy.

"Team Members Responsible" refers to the specific person/s who will implement the support role/treatments. "Review Date" is a date set by the care coordinator and consumer when it seems reasonable to review that strategy – it may be the same as the 3-monthly review date, or it may be sooner, depending on the strategy.

Progress of Care:
The table at the bottom of each page provides an opportunity to record strategies that have been attempted in the past, relevant to the category. By recording what has been attempted, whether it worked or not and why, and when it was attempted, clinicians and consumers can have an overview of progress, and a historical reference of past treatments and programs.

If a strategy has been recorded in the progress of care, this doesn't mean that it will no longer be relevant to the consumer, or can't be tried again. It's important to remember the situation and context of treatments, people involved, etc and how these may influence outcomes. Details in this table can provide clinical teams and consumers with valuable insights into how the journey of recovery has developed so far.

Recovery and Relapse Prevention Plan (RRPP)
The RRPP is on the last page of the ICP. It provides an opportunity to record ways for consumers, carers and clinicians to identify triggers, relapses, ways of coping with stress and managing crisis situations. This section can be completed in a number of ways:

- by the consumer on their own;
- by the consumer with help from the care coordinator/clinician (e.g. in a discussion, with the clinician writing things down);

- with input from carers or family;
- using information from the Strengths Assessment;
- a combination of the above.

This is a tool that is 'owned' by the consumer, and can support the consumer to think of what to try in stressful or crisis situations. It is something that may change a little or a lot with each review, as consumers develop different coping mechanisms and learn how to identify triggers and symptoms more easily. This is not a tool that can be completed just by the care coordinator or clinician, though they can help the consumer to identify what works for them through questions, prompts and examples.

Tips on completing the ICP and RRPP:

Only sections that are relevant for the consumer for that period need to be completed

For example, if the consumer doesn't have any substance misuse issues, it is only necessary to complete the tick box at the top of this category, and the rest can be left blank. Likewise, not all sections need to have lots of strategies or goals. Consider what is specific and achievable for the next three months.

If a consumer doesn't consider a category relevant, but the clinical team does, this can still be completed with strategies developed – bearing in mind that there may not be much in the "consumer actions" column. For instance, if a consumer does not feel they have a substance misuse issue, but the clinical team are concerned by their drug use, there may be strategies developed around education and the use of motivational interviewing; the consumer may only agree to "listen to information given" as part of the consumer actions.

"Strategies" are the short-term goals that are specific, measurable, and achievable.

Developing goals that work is a skill, and is an important way of ensuring that a care plan is individualised to the consumer. The strategies are the short-term goals that provide the "baby steps" to attaining the goal statement. They are developed by breaking down goals into the small steps required to reach the goal. Strategies should be:

- Stated in positive terms
- Have a high probability of success (so start with the smallest "baby steps"!)
- Measurable and observable
- Specific (not vague) and time-limited (has a review date)
- Understandable and meaningful to the person

For example a goal statement might be "I want to be an actor". Using solution-focused questioning, you might elicit from the consumer that she thinks to be an actor, she needs to look good, needs to know about drama and acting, and needs to see some live performances to find out more. Strategies might then break down further to be:
"I will get my hair cut and styled"
"I will borrow some plays from the library to read the parts"
"I will save money to buy a ticket to see a live theatre show when I'm on leave"

The big goal statement may actually break down to goal statements for different sections of the ICP, eg with the above example, the consumer may decide she'd like to lose weight and be more physically fit to be an actor, and she might have a goal of joining a drama group as her goal statement in the Leisure/recreational section.

Short term goals/strategies can be written using the 'SMARTA' approach:

S pecific
M easurable
A chievable

R elevant
T ime-framed
A greed upon

Care Coordinators can assist consumers in setting SMARTA goals, by helping them break large or long-term goals into smaller, achievable steps, and getting the consumer to consider how they will know when they have reached that goal. Often, setting smaller, specific and concrete goals can help the consumer see when an outcome is achieved and provide a clearer direction.

Examples of the SMARTA approach:

- *Good:* Jacob will independently engage in one leisure activity in the community on a weekly basis by the next review.
- *Not so good:* Jacob will increase his community outings.

- *Good:* Anne will use a washing machine to wash her clothing with staff supervision once a week by 4 weeks.
- *Not so good:* Anne will wash her own clothes.

The actions should then reflect the step-by-step approach needed to achieve the goal.

The Goals/strategies/actions care plan is one way of recording goals and outcomes for consumers. Other ways that may complement the ICP and help consumers include:

- Pictorial representations of goals
- Writing goals in the consumers' own words
- Using an audio cassette recording of the goals and their steps.

Whichever means of recording goals that is used, a copy or version of the record, which reflects the same goals, strategies and outcomes, should be provided to or discussed with the consumer, and a copy kept with the ICP in the clinical chart.

Risk Screen Tool

Suicide/Self Harm, Violence, Vulnerability and Absent without approval can present serious problems for all concerned. The state-wide standardised Risk Screen tool has been developed to better manage these behaviours. The Risk Screen is completed on admission and reviewed at least three monthly (more frequently in some clinical areas). Ad hoc assessments of risk are also carried out when there is a change in the consumer's behaviour (or risk factors), a critical incident or prior to transfer or discharge. This Risk Screen Tool is a template on CIMHA.

The first component of the tool is a checklist of prompting questions regarding static and dynamic risk factors. Static factors are those factors which do not readily change (e.g. age) while dynamic factors change over time and are amendable to intervention.

Below the checklist there is a free text field for details regarding risk and mitigating factors. The most important part of the risk assessment is the information recorded in this section. The comments noted should yield the information required to: generate a risk rating; and, to support the clinical decision making process behind the rating documented. For example, if a risk history has been identified in the checklist further explanatory information can be provided here: e.g. *"Joe has made suicide attempts in the past but has not had a known episode of self harm or suicide attempt for approximately 10 years."*

This detail may support the decision to rate Joe as a low risk of suicide. The risk history in both the checklist and free text fields should cover all past clinical history.

There is a Child Protection Risk Screen asking if the consumer has any custody or care responsibilities for children. If yes, a Child Protection form must be completed on CIMHA. This is followed by a box requiring the allocation of an overall risk rating.

The final section is for **Clinical and Risk Formulation / Assessment Summary** which is a free text field designed to capture detailed consumer-specific information to enable effective and appropriate clinical risk management. Information to include in this section:

- Protective and mitigating factors
- Stressors
- Strength and supports
- What will increase or decrease the consumer's risk?
- Is the consumer possibly in early psychosis or prodromal?
- Consider historical information in relation to current dynamic and contextual factors
- Where risks are identified, document strategies to address the identified risk factors

The Risk Screen tool is a standardised template on CIMHA. While a Care Coordinator generally completes the Risk Screen, the management of the risk should be a team effort and not the responsibility of any one individual.

The data gleaned from the use of Risk Screen is likely to be useful in decision making around risk – however, it is only one aspect of risk assessment and should never override clinical judgement. However, it is important that the Risk Screen be reviewed as required and revisited to reflect any changes in behaviour.

Other risk tools used in clinical areas may include the DASA and HCR-20.

See Appendix D (page 41) for an example of a Risk Screen tool.

Outcome Measures

The emphasis on health outcomes and information systems to support quality improvement has been gaining momentum in the wider health sector for several years. The implementation of routine outcome collection in 2004 by all Queensland mental health services, has led to services becoming more able to explore and ask questions about the benefits or otherwise of the treatment or care they provide and the complexity and characteristics of the populations they serve. Services have also begun to use the information to explore the connections between service provision and changes in levels of consumer well-being.

The outcome measures used also provide important information for care planning. Examples of how the information can be used in the clinical setting include:

- To monitor the progress of consumers receiving mental health services.
- As a clinical tool to inform treatment planning.
- To evaluate the effectiveness of treatment and individual care plans.
- To increase dialogue amongst members of the treating multidisciplinary team.
- To facilitate engagement and partnerships with consumers and carers in care planning.
- To assist in professional supervision.

Table 1 outlines the suite of measures generally used by Child and Youth, Adult and Older Persons mental health services.

Child and Youth Services	Adult Services	Older Persons Services
CLINICIAN RATED / COLLECTED		
• Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) • Children's Global Assessment Scale (CGAS) • Factors Influencing Health Status (FIHS) • Principal Diagnosis (ICD-10-AM) • Mental Health Legal Status	• Health of the Nation Outcome Scales (HoNOS) • Life Skills Profile (LSP) • Focus of Care (FoC) • Principal Diagnosis (ICD-10-AM) • Mental Health Legal Status	• Health of the Nation Outcome Scales for Older People (HoNOS65+) • Life Skills Profile (LSP) • Focus of Care (FoC) • Resource Utilisation Groups - Activities of Daily Living Scale (RUG-ADL) • Principal Diagnosis (ICD-10-AM) • Mental Health Legal Status
CONSUMER SELF-REPORT		
• Strengths and Difficulties Questionnaire (SDQ)	• Mental Health Inventory (MHI)	• Mental Health Inventory (MHI)

The Outcome Measures are completed on CIMHA according to a collection protocol. You can also access hardcopy forms from QHEPS or from *G:\Care Planning\Package of Tools\Outcome Measures* when the CIMHA system is down, for consumers to complete their tools, or if your clinical team prefers to complete the tools together. For more detailed information on accessing tools and how and when to complete the measures, talk to your supervisor and go to http://qheps.health.qld.gov.au/mhinfo/outcomes.htm for resources. Your clinical area should also have a copy of the ***Clinician's Handbook Outcomes Initiative*** and ***Beyond Outcomes Desktop Flip-Chart*** available for your reference.

The Individual Care Plan now includes in each section a reference to the HoNOS and LSP scores relevant to that health/life domain. This provides an easy reference for clinicians to see how goals relate to clinically significant scores. See the section above on completing the ICP for more information.

Strengths Assessment

Adapted from "Strengths Model for Special Care Settings" by Paul Liddy. Available from G:\Care Planning\Strengths Model

The Strengths Assessment is a tool designed to help the client and care coordinator become conscious of the resources a person possesses, not only at this point in time but also what they have accumulated in experience and knowledge in the past and what external resources they possess or have access to. The form is available via *G:\Care Planning\All Tools - Care Planning Package\Consumer tools*. See *Appendix C* on pg. 39 for an example.

The middle column of the Strengths Assessment asks the question "What do I want?" This is at the very heart of the work we do with people and getting this dream or aspiration is critical to moving recovery forward. From the middle column a list of priorities is distilled and work can begin on a chosen goal using the recovery goal worksheet.

All of this does not happen at once and a varying amount of time must be invested in simply engaging with the person so as to gain trust and build a partnership. During the course of multiple conversations, strengths will become apparent, be noted and begin to populate the Strengths Assessment. At first the tool may lack an amount of detail but over time and with increasing engagement it will become more specific and thorough.

Certainly the style of a Strengths Assessment should mimic a conversation that proceeds at the person's pace and is smooth and natural. The aim is to gain information that is genuine and meaningful to the client rather than simply what they think that you want to hear. Many frustrations and failed goal attempts come from forcing the Strengths Assessment upon people and treating it as a piece of one time paperwork rather than as an active living tool which will be added to and refined continuously over the course of engagement.

What the Strengths Assessment is aiming to capture and clarify are the qualities, talents, skills, resources and aspirations that a person has for their recovery journey. One would not expect to see a collection of deficits or negative comments. There is usually nothing contained within this information that helps people be successful. But have no fear, any relevant limitations will be uncovered during the goal planning phase and can be viewed positively as challenges to be overcome. Recording them on the Strengths Assessment, however, can have the effect of limiting the vision of participants to the possibilities, effectively closing the door on potentially viable alternatives.

If you have never attempted a Strengths Assessment with a consumer before, it may be helpful to try it out on a colleague, friend or family member first – just have a brief conversation, and see what strengths you can identify, along with your current knowledge of the person.

Personal Qualities

This box on the second page gives an opportunity to capture those personal strengths which may not fit neatly into the domains. Qualities such as "friendly", "enjoys the moment", "has a great sense of humour", "generous", "tenacious" etc might be written here.

Prioritising goals

The Strengths Assessment builds up over time, and it may be difficult to know which aspirations are most important to the consumer at any one time. At the bottom of the Strengths Assessment is a box which allows the consumer to highlight the three priorities for goals or aspirations. These priorities should be reviewed every three months when the care plan is reviewed, to check for changes in priorities and whether any goals have been reached.

Life domains

The following lists are sample areas to explore in each life domain. They are not exhaustive or prescriptive and should NOT be used as an interview or interrogation! Remember that this process of Strengths Assessment is ongoing and continues for the length of the recovery journey. A relaxed and positive style will more likely elicit useful information than a style that is rushed or forced. Taking time early will potentially save time in the long-term!

Areas to Explore through the Strengths Assessment

Mental Health

Present moment
- How do you see or understand your illness?
- Medications. How do you manage your medication? How do you handle side effects?
- Do you experience symptoms of your illness? What are they like? What kinds of things do you do to cope with or manage your symptoms?
- What produces stress for you? What do you do to manage stress?
- Coping tools and strategies – what are you doing now to stay well?
- Who do you find it useful to talk to when your feeling down or unwell?

Link to Recovery and Crisis Prevention Plan

Desires/Aspirations
- As suggested by the consumer in their own words. For example:

"To get out of this place."
"Being able to stop the voices"
"Knowing when I'm getting sick."
"I want to be able to relax."
- Consider miracle question. If you woke up tomorrow and the illness was gone.....what would you be like? What would you do?
- Are there things you'd like to manage better in terms of your mental health?

Resources
- Care coordinator, care coordinator
- Family, Friends
- General practitioner, Psychiatrist
- Support groups, community groups (eg church, NGOs, sports teams)
- Recovery and Crisis Prevention plan / relapse management plan
- Identify what has worked in the past. If unable to identify, ask what the person was doing when they were well/ before becoming unwell.

Physical Health, Nutrition, Activities of Daily Living

Current Status
- How would you describe your health at present?
- Is being in good health important to you? Why/why not?
- What kinds of things do you do to take care of your health or to stay healthy?
  - Medical Doctor currently seeing
  - Dentist
  - Diet and eating habits
  - Do you exercise? What type?
  - Use of over the counter medications.
  - Birth control
  - Smoking habits
- What are some of your daily habits or routines? How do you take care of your personal hygiene and appearance?

Desires/Aspirations
- Are there things you are working on or would like to work on with regard to your physical health? (e.g., losing weight, managing symptoms, smoking less, drinking less, healthy eating, etc.)
- What is important to you in this area? Is there anything you would like to learn more about, improve or change in this area?
- Are their habits or routines that you'd like to develop to look after yourself, your appearance and your hygiene?

Resources

Address resources used in the past for any of the areas mentioned in current status.
- What healthy practices have been used in the past?
- What educational sessions have been offered in the past, did this help?
- Previous lifestyle behaviours that promoted/improved physical health?
- Previous interest in physical activity/sport/cooking?
- Were any of the resources used in the past (DR's, hospitals, exercise activities, medications, diets, symptom management techniques, etc.) particularly helpful?
- How were ADLs performed in the past?

Daily Living Situation/Financial

Current Status
- What is good about where you live? What do you like about where you live? (e.g., warm, good food, activities, etc.)
- Do you have a TV you can watch?
- What personal assets related to daily living does the person have? (e.g., Do you have a radio, music player, TV, etc.?) Not: This can help identify wants – does the person wish he/she had a computer?
- Are there details, special attributes about the setting that the consumer is proud of or enjoys? (eg collects things, paintings, is particularly tidy, embroiders, has aquarium, etc.).
- What does the person enjoy doing or is good at doing in terms of daily living task if anything? (e.g., cooking, cleaning, grooming, etc.)

- Do you have a bank account? What kind?
- Payee? Name & address
- How do you budget & manage your

Desires/Aspirations
- Do you like where you live? When you leave the facility where would you like to live?
- Do you like living alone? With other people?
- If you could change one thing about your living situation, what would it be?
- What would your ideal living situation be? (e.g., living on a farm, buying a home, etc.)
- Is there anything you would want to make your living situation easier? (e.g. a music player, posters, books, etc.)
- What is most important to you in your living situation? (e.g., feeling safe, people to talk with, private space, etc.)

- What would you like to be different with regard to finances? How?
- What is important to you regarding you

Resources
- Where have you lived in the past (list each)? With whom? For how long? What was the type (apartment, group home, house, nursing facility) and location?
- Are there things you really liked about any of the past living situations?
- What was your favourite living situation? Why?
- Are there things you had in a past living situation that you do not have now but you would like to have again?

- What was the person's income in the past? From what sources? (e.g. Has the person worked in the past? Did they get benefits they do not receive now?)
- Did the person use/have any resources in the past

money?
- How do you pay your bills?
- Do you have extra spending money each week? How much?

Income (type and amount), eg:
- Centrelink (DSP, etc), DVA
- Income from work
- Family/friends loans/assistance

finances? (e.g., I want extra money each week to buy treats; I want to be able to rent movies; I wish I had a savings account, etc.).
- Are there benefits the person is entitle to, but is not getting?

that they are not using now? (e.g., payee, taking a financial management class, used to have a savings/checking account, etc.)

Vocational/Educational

Current Status

- What is the person doing with regard to productive activity? Include type, where, and amount of time. (e.g., Correspondenc classes in art, self-paced learning on a topic of interest).
- Activities that could be included in this category: volunteer work, school, odd job helping others, etc.
- Highest level of education (e.g., GED, hig school, 22 hours of undergraduate work, B.A., etc.)
- What do you like about your current activities, etc.?
- What is important to the person about what they are doing? (e.g. "I like the extra money", "helping people", "being around people", "being in charge of something", etc.)

Particularly if the person is not doing anything in this area, what are their interest skills, abilities related to productive activity? (e.g. "I'm very mechanical", "I enjoy the outdoors", "Art is my passion", etc.)

Desires/Aspirations

- Do you have any desire to work? Go to school? Volunteer? Earn extra money?
- If so, what would that be doing? What do you enjoy doing? What do you have experience doing? (e.g., "I'd like to get a nursing degree", "I like to wo outside and with my hands", "I like helping people", etc.)
- If you could be or do anything you wanted (career-wise), what would that be? What is it about that that interests you?
- If the person is doing some type of activity currently, is the person satisfied with what they are doing? Is there anything about what they are doing they would like to change? Is there any other activity they would like to do in addition?

Resources

- What type of activity (work, school, volunteer work, training, etc.) have you done in the past? For how long? When? Where? What did you lik or not like about it?
- What kind of vocational services have you received in the past?
- Have you been/are you on any work incentive programs?
- What work situations have you found most enjoyable and why?

Social Supports/Spirituality*

Current Status

- Who do you spend time with? Who are your friends? Who do you feel close to? Who makes you feel good when you're around them?
- Do you have anybody that comes to visit you or that you spend time with? What kinds of things do you do together?
- Do you have a pet? Would you like one?
- Do you have visits from any members of your family? Are the visits pleasant or stressful? Do you rely on any members of your family for support?
- What is it you like and dislike about being with other people?
- What is it about being alone that you like? What kinds of things do you do when you are alone? What do you do when you fee alone?

- Is there anything in your life that brings you a sense of comfort, meaning, or purpose in your life?
- What gives you the strength to carry on in times of difficulty?
- What do you believe in?
- What do you have faith in?

Aspirations/Desires

- Is there anything that you would like to be different in your social life?
- Are there any areas of you life you would like to have more support in? (e.g., spirituality, better relationship with family, more friends, someone to share your interests, etc.)
- Are there organizations, groups, clubs that you do not currently belong to, bu would like to? (e.g., church, rotary club, book club, astrology club, etc.)

- Are there beliefs and values you'd like to learn more about?
- Are there steps along your spiritual journey that you'd like to reach?
- Would you like to explore your faith further? How might you do that?

Resources

- Have there been important people in your life (e.g., friends/family) that you have felt supported by in the past but currently do not spend time with? Who?
- Are there places you used to hang out/ people you used to hang out with that you do not currently? Describe who and where.
- In the past, did you belong to any groups, clubs, and/or organizations? What were they? Did you enjoy them? What did you enjoy about them?

Examples of past or current spiritual activities or pursuits may include:
- Meditation
- Art
- 12-step programs
- Temple
- Music
- Community service
- Organised religion
- Nature
- Fellowship with others
- Political justice
- Altruism/giving

*Definition of spirituality
Spirituality refers to any set of beliefs and/or practices that give a person a sense of hope, comfort, meaning, purpose in their life, or a connection to the greater universe. For some people this may have to do with God and some type of organized religion, for others it may be a individual relationship with a higher power, for others it may not be specifically defined. Religion is not necessarily synonymous with spirituality.

Do not limit the definition to only an institution, church, or denomination. Also, do not impose your own thoughts or beliefs on the person.

Leisure/Recreation

Current Status
- What do you do for fun?
- What are your hobbies?
- What do you do to relax and enjoy yourself?
- Do you ever go out on leave, escorted or unescorted? If so, what do you usually dc
- Do you have a TV? Would you like one? What is your favourite TV show? Do you like movies? What kind? Who is your favourite actor?
- Do you like to read? Who is your favourite author/type of books?
- Do you like to cook? What is your favourite meal?
- What talents do you have? What are you hobbies?
- If you could do anything you wanted for one day, what would you do?
- When do you get bored? What do you dc when you get bored?

Desires/Aspirations
- What fun things do you like to do, but are not doing currently?
- Have you ever wanted to try something that sounded like fun, but you never have done?
- Explore desires listed in current status.

Resources
- Explore past involvements, interests, activities listed in current status. Where did the person dc the activities? With whom?
- What activities did you most enjoy in the past? What was it about the activities you enjoyed?

Frequently Asked Questions about the Strengths Assessment

(1) "How do I proceed if the person says they don't want to fill out the strengths assessment?

Always remember the fourth principle - the relationship (not the assessment form) is primary and essential. The care coordinator should always use the strengths assessment in the context and flow of the relationship, not as a static document that is forced on a person whether they like it or not. If the person is resistant to having information about them written down in this manner, respect their decision. You can fill out a strengths assessment on your own simply as a way of keeping track of the client's strengths for your own recall.

Every few meetings try introducing the document in a new way. Be sure to focus on the fact that this is not a typical "treatment" form, but rather a way to keep track of the abilities, strengths, and dreams that the person wants to achieve. When people understand that the strengths assessment is not the typical deficit, professionally directed form, but rather a celebration of all that makes them unique, they usually become more willing to give it a try.

(2) "What if the person has a history of criminal behaviour, suicide attempts, or alcohol or drug abuse, but they don't want it to be on the form? Do you just leave it out of the assessment?"

The short answer to this question is... yes. The strengths assessment is a document that is directed by the client. Many consumers may be able to reframe such things as past criminal behaviour or an addiction as a strength (e.g., how far they have come, what they have learned through the process, etc.) or as a goal (e.g., I want to take my 12 step program more seriously). However, if it is not something the person wants to be on their assessment, that choice must be honoured. As a trusting relationship develops, this information may be something that will come up at a future time.

Remember, the strengths assessment is not typically the only written assessment that is completed by the mental health agency. For billing, legal, or other risk assessment protocol most programs require a complete psychosocial history be completed in the first few weeks of intake. These documents may include important information related to past behaviour to assess for risk that the care coordinator may need to know. However, they do little to inspire the hope and future focus that promotes recovery. Some agencies have a separate intake worker fill out the initial psychosocial assessment at intake rather than the case manger. This separation helps to keep the primary helping relationship with the care coordinator focused primarily on strengths.

(3) How do you keep the strengths assessment as an on-going, working document?

Remember – the strengths assessment is a "working document". This means that it is constantly being updated. The strengths assessment can be added to or amended at any time but it is most beneficial if this can be done in conjunction with the client. The client should have a recent copy and there should be a recent copy in the chart to be referenced by other staff (e.g., vocational counsellors). Remember, the strengths assessment is not paperwork, but a central tool to promote recovery and growth. Do not let it get buried in the chart with all the other forgotten forms!

(4) "What if the person gives you information that you think is delusional (e.g., "What is your income?" "I receive a million dollars a year from the FBI.") Do I write that down?"

The short answer, once again, is...you guessed it – yes. Writing something down on the strengths assessment does not imply that we fully agree with it. The strengths assessment is a record of what the consumer tells us about themselves, their ideas and beliefs, not our opinion of the validity or "truth" of their views. If we were to not write this information down (or worse yet, attempt to convince the consumer that what they are telling us is false) we will run the risk of breaking the trust that is the foundation of the helping relationship.

What we should do is seek to learn more and find out what is underneath people's perceptions about themselves. For example, if someone were to say, "I have a telepathic relationship with my boyfriend in New York," we might explore with, "What about your relationship do you enjoy? What parts are difficult?" When done with good clinical skill and genuine interest, this type of exploration does not reinforce a harmful delusional system but rather sets the foundation of trust and safety that people often need to step out into recovery.

Consumer Participation Plan

- The Consumer Participation Action Plan should be completed on admission for consumers who have identified communication issues, and reviewed (or revisited) every three months. The form is available via *G:\Care Planning\All Tools - Care Planning Package\Consumer tools*
- If there are no changes to the information collected in the Consumer Participation Action Plan – the tool DOES NOT need to be re-done. Simply re-date the tool and review it at the Individual Care Plan review presentation at the Team Meeting.
- There are three sections to the tool. Each section covers a different aspect of participation-
  - The first column provides a few options for the consumer and the care coordinator to consider. Read through each question together with the consumer. The consumer may want to choose more than one option (or alternatively, the consumer may want to choose options that are not listed on the tool). Where appropriate, point to the graphics to assist the consumer to focus on each option. The care coordinator may also decide to use some follow-up questions to gather more information from the consumer on a particular item.

- The middle column is used to record the consumer's **preferences** in relation to the questions in the first column. This gives an opportunity for the care coordinator to acknowledge exactly what the consumer wants- even if it is impractical. This column should be completed by the consumer. The consumer should write down exactly what they want, including information about who should be involved, and when (or how often) they'd like for things to happen (e.g., I want to attend the team meetings every time my Care Plan is reviewed, with my carer). The care coordinator can assist the consumer to write down their preferences – but at this stage, it should be about finding out what the consumer wants, and helping them to define this more clearly.

- The third column is used to record the "agreed actions" arising from what the consumer has identified in the middle column. This column should be completed by the care coordinator. This column should reflect the final outcome of any negotiations between the care coordinator/treating team and the consumer as to what is achievable. The care coordinator should write down specific and detailed (who, what, when) **actions** that should be carried out to meet the consumer's identified preferences and needs (e.g., Care Coordinator will provide a reminder when the Care Plan review is on- a week in advance, and also on the day the Care Plan is presented at the team meeting). The "agreed actions" should be discussed at the Individual Care Plan review meeting and approved by the multidisciplinary treating team.

Drug Check and AUDIT

The Drug Screen and AUDIT are the standardised tools to be used for screening of alcohol and drug problems for adult consumers at The Park. These tools are available as templates on CIMHA.

It is suggested that these tools are used with in the following way:

On Admission:

- The Consumer Assessment form on CIMHA should be completed by admitting staff, which includes a drug check to identify potential problems or hazardous use. A copy is to be included in the clinical file.
- The AUDIT should be completed on CIMHA by admitting staff or the care coordinator/associate, with a copy in the clinical file.

If a problem of use is identified with these tools:

- The full Drug Screen tool on CIMHA should be completed with the consumer, which includes the Severity of Dependence Scale and brief Readiness to Change assessment.
- The Problem List (on CIMHA) and complete Readiness to Change Questionnaire (*G:\Care Planning\All Tools - Care Planning Package\D&A Screening tools*) are to be completed with the consumer for each problem substance identified.
- The clinical team may also use other assessment tools that they feel are appropriate.
- The results of these screening tools should be fed back to the clinical team and possible interventions discussed, if required.

Reviews:

- For those consumers identified as having a problem with substance misuse, the Drug Screen and AUDIT should be completed with each care planning review every 3 months, or on a frequency determined by the clinical team. The Problem List and additional tools may be completed every 12 months or when clinically indicated, e.g. in planning transition or discharge.
- For consumers who do not have an identified substance misuse problem, review using the Drug Screen & AUDIT should be done annually.

Other/Ad Hoc:
Use of the screening tools is also recommended for consumers who are not regularly screened in the following situations:

- If the treating team suspect that the consumer has recently commenced or recommenced using drugs/alcohol.
- If the consumer returns a positive urinary drug screen.
- If the consumer admits to having used or had access to drugs/alcohol.
- If there is a score of 2 or higher on item three of the HoNOS at any 3 monthly review.

The assessment results should inform care planning. **All consumers with an identified substance misuse problem should have relevant treatment goals and strategies written in the Individual Care Plan.** Please see the Drug & Alcohol Clinical Pathway as a reference point for possible treatment options.

What if the consumer refuses to complete the tools?
If the consumer refuses to participate, the team can still identify potential drug use issues using other sources, e.g. past history, observation, clinical notes, relatives, referring agencies. Treatment and interventions should still be planned, and assume that the consumer is at a pre-contemplative stage of change (see "Stages of Change" document in *G:\Everyone\Drug&Alcohol\Stages of Change.pdf*). It should be noted in the care plan if the consumer has not participated in the screening and assessment process.

Notes about the tools:

- Attempt to get at least two sources of information to complete the screening tools, usually the consumer and another source (clinician, family member, clinical chart, etc).
- Scoring guidelines are provided on the tools for the Drug Screen & AUDIT.
- The Readiness to Change Questionnaire provides a guide to which stage of change the consumer is at in relation to their substance use. This can assist clinical teams in deciding on appropriate interventions to attempt with the consumer.
- All tools are available at *G:\Care Planning\Tools\D&A Screening Tools* OR *G:\Everyone\Drug&Alcohol\Screening tools*

Involuntary Patient Summary

The *involuntary patient summary* maintains current information that is pertinent to risk assessment and risk management. This form is a template on CIMHA.

The purpose of the summary is to ensure information is readily available to front line and mental health staff, particularly for those who are unfamiliar with the consumer. Completion of the summary is mandatory for all forensic patients and classified patients; however, the summary may also be completed for patients under involuntary treatment orders.
The summary must:

- include diagnosis; *Mental Health Act 2000* status; LCT provisions and conditions; offence history; contact details of the treating service and any other pertinent information
- be completed in CIMHA every three months and more frequently as new information presents, such as AWOP incidents or new offences are accrued
- at each update, a hard copy is to be placed in the front of the clinical file and MHA Administrator's (Medical Services Officer) file. **Please ensure that the MSO either receives a hard copy, or is notified when an IPS is updated on CIMHA.**

Information recorded in the summary should be relevant to risk management and risk assessment. Information from the summary may be transcribed onto the *Additional Information to accompany authority to return patient to AMHS* form, as appropriate.

Carer participation and sharing information with carers

Carers, family and friends are an important support and resource for consumers, source of information for mental health teams, and can greatly assist in working towards recovery goals. There are issues that need to be considered, however, in terms of the consumer's consent for carer involvement and information sharing.

The *Consent to Carer/Family/Friend Involvement in Care* form is a way to record a consumer's consent for family & friends to be involved, how they wish to be involved, and provides a record of up-to-date contact details and special considerations.

This form is to be completed on admission, and revisited during care planning review to ensure that recorded details and consumer's wishes remain current. A copy is to be sent to the Clinical Initiatives Coordinator so that carers may be sent information packs and be included in The Park's carer database. The form is accessible from *G:\Everyone\Carer Participation\Consent to CFF Involvement in Care.doc.* See *Appendix E*, page 43 for an example of this form.

A *Carers, Family and Friends - Involvement in Care* information sheet (*Appendix F*) is also available for care coordinators to discuss with consumers the benefits of involving carers and the consumer's and carer's rights in terms of consent and information sharing. The fact sheet is available from *G:\Everyone\Carer Participation\Fact Sheet.Consent Involvement in Care.doc.*

For more information on carer participation at The Park, contact Consumer Services or the Clinical Initiatives Coordinator.

Mental Health Child Protection Form

The *Child Protection Form* is a standardised note template in CIMHA. The *Child Protection Form* should be completed, saved and signed electronically on CIMHA. A hard copy must be printed and filed behind the Individual Treatment Plan divider of the clinical record.

The following process applies to all consumers who are current consumers with a mental illness and have care responsibilities (on a full-time or periodic basis) to children under 18yrs. "Care responsibilities" for a mental health consumer who is an adult (18yr+) with a mental illness includes:

- biological children and children within a step or de-facto relationship; and
- children for whom a mental health consumer has care responsibilities on a full-time or periodic basis (including access arrangements to own children or sole care of partner's, housemate's or friend's children)

Admission

On every admission to the clinical area the Care Coordinator (CC), in collaboration with the clinical team, must aim to identify any children (0-17yrs) for whom the consumer has care responsibilities (see definition). This information should be sought through consumer interview and collateral information. If the consumer is unable or unwilling to provide information regarding their care responsibilities for children, collateral information must be sought. This is to be conducted with the informed consent of the consumer.

If it is identified that the consumer has care responsibilities for children, the *Mental Health Child Protection Form* must be completed. This form identifies:

- the demographic details of the children
- the immediate welfare needs of the children
- the presence (or absence) of an immediate reasonable suspicion of child abuse and neglect at the time of completion of the form necessitating a report to the Department of Child Safety.

In the event a *Child Protection Form* has already been initiated by another Mental Health Service, this form should be reviewed to ensure all information is correct and up to date and reporting is to be initiated as required (see section on Reporting Reasonable Suspicion).

On admission, the CIMHA system also requires identification of child protection issues. The user registering the admission will be required to respond to the following question:

'Does the consumer have custody or care responsibilities (either on a full-time or periodic basis), to any child/ren (0-17 years) in their current living address?'

If unknown at time of admission the registering user should tick *'No'*. In the event a *Child Protection Form* is initiated, this section of the service episode information in CIMHA should be updated accordingly.

If deemed necessary by the clinical team, where a consumer has custody or care responsibilities, a *Family Support Plan* and *Child Care Supplement Plan* can also be completed at this time. These forms are available on CIMHA.

Review

The *Child Protection Form* should be reviewed by the CC, in collaboration with the clinical team, at the three monthly Care Plan review. The form should be updated and reporting initiated as required (see section on Reporting Reasonable Suspicion).

Review of the *Child Protection Form* should also occur when there has been a change in the consumer's status in regards to their care responsibilities for children, e.g. gives birth, change in accommodation, relationship changes.

Discharge

The *Child Protection Form* should be reviewed by the CC in collaboration with the clinical team, prior to discharge. The form should be updated and reporting initiated as required (see section on Reporting Reasonable Suspicion).

Upon ending the service episode in CIMHA the following questions will need to be answered:

1. *'Does the consumer have custody or care responsibilities (either on a full-time or periodic basis) for a child?'*

   If *'Yes'* is entered in response to the above question the following will be asked:

2. *'Has an assessment been conducted using the 'Guidelines for the consideration of issues related to the impact of mental illness on a consumer's parenting role Assessment of the Impact of Mental Illness on Parenting'?'*

   A response of *'No'* will require a reason as to why this has not been completed.

Reporting Reasonable Suspicion of Child Abuse and Neglect

If a Queensland Health employee has reasonable suspicion of child abuse and neglect, a report should be made to the Department of Child Safety. This report should be based, wherever possible, on a comprehensive clinical assessment of both the risk and protective factors impacting on the child or young person.

For information and assistance in relation to reporting reasonable suspicion of child abuse and neglect contact the CNC Child Protection on [redacted] or pager 331 during business hours. The form for reporting to the Department of Child Safety can be found in the Child Protection Resource Folder located in each unit or online at http://qheps.health.qld.gov.au/csu/pdf/scan_forms/form_interactive.pdf

Other Assessments/ clinical area tools

Your clinical area may have a number of other tools that are used to assess and plan the clinical needs of consumers. For more information on these, and how they are used in your area, talk to your Clinical Nurse Consultant or clinical supervisor. Some of the tools used in the clinical areas include:

For Extended Treatment and Rehabilitation/Dual Diagnosis:

- Medication Self-Management Checklist
- ETR & DD Consumer and Family Consultation Form
- ADL Checklist

For High Security:

- HCR-20
- DASA

Other tools include, but are not limited, to:

Assessment Checklist Cultural Diversity – for use with people from culturally and linguistically diverse backgrounds. The care plan includes a prompt question and link to this form.

Clinical Chart Audit – is a quality improvement tool to ensure that clinical charts and documentation are meeting national accreditation, Queensland Health, and local standards. These are generally completed by the care coordinator as they review the clinical documentation in preparation for care plan reviews every three months.

Crisis Intervention Plan – used particularly with forensic clients, or those at high risk, as a communication tool. Outlines the risk management and crisis intervention plan for the consumer, e.g. whom to contact and how to respond to the consumer in a crisis. Useful for sharing with police, community services and family as part of a consensual intervention plan. The Crisis Intervention Plan is a standardised tool on CIMHA and is to be completed in consultation with the Forensic Liaison Officer (FLO).

Inter-Service Communication Plan – formerly, the Crisis Management Plan, this form was developed for forensic clients, or those at high risk, who are accessing more than two nights unescorted leave in the community. It is provided to receiving services and agencies including supported accommodation service contacts, family members, approved responsible adult and provides information on risk management, e.g. whom to contact and how to respond to the consumer in a crisis. The Inter-Service Communication Plan is unique to The Park and is to be completed in consultation with the Forensic Liaison Officer (FLO).

Resources

Relevant G:drive directories:

G:\Care Planning (includes the package of tools, audit results, and relevant information)
G:\Everyone\Carer Participation (includes forms, fact sheet, and carer participation plan).
G:\Care Planning\CIMHA (includes training resources, fact sheets and relevant information).
G:\Everyone\Drug&Alcohol (includes tools and relevant information).

Workplace Instructions on care coordination available from:

G:\Everyone\Workplace Instructions – All Areas

Strengths Model Information available from:
G:\Care Planning\Strengths Model

Library resources/references:

Rapp, Charles A. & Goscha, Richard J. (2006). *The Strengths Model: Case management with people with psychiatric disabilities*. New York: Oxford University Press. (Available on interlibrary loan).

Rapp, Charles A. (1998). *The Strengths Model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press.
(From The Park library call no. 362.20425STR 1998).

Walsh, Joseph. (2000). *Clinical case management with persons having a mental illness: A relationship-based perspective*. Belmont: Wadsworth.
(From The Park library call no. 362.20425CLI 2000).

Repper, J. & Perkins, R. (2003). *Social inclusion and recovery : a model for mental health practice*. New York : Baillière Tindall.
(From The Park library call no. 362.20425 SOC).

Perkins, Rachel & Repper, Julie. (1999). Working alongside people with long term mental health problems. Cheltenham : Stanley Thornes.362.2042562 WOR

Ralph, Ruth O. and Corrigan, Patrick W. (eds) (2005). Recovery in mental illness : broadening our understanding of wellness. Washington, DC : American Psychological Association. 616.891 REC 2005

Hall, A. , Wren, M., & Kirby, S. (eds) (2008). Care planning in mental health : promoting recovery. Oxford : Blackwell Publishing. 616.890231 CAR 2008

Appendix A

The Park - Centre for Mental Health

CARE PLANNING PACKAGE CHECKLIST

Affix Patient ID Label Here

- The tools listed below are the required documents that make up the Care Planning Package. These tools need to be reviewed every three months. Additional tools that are specific to clinical areas or specific patients can be added as required.
- Indicate in the tick box once each assessment has been completed, reviewed, refused or is not applicable (N/A).
- Ensure all documentation is signed by relevant parties ie. Care Coordinator (CC), Doctor &/or Consumer where possible

Date:	/ /	Review type:	New periods ☐	Standard Review ☐	Ad Hoc Review ☐	End of Episode ☐
Risk Screen Tool	Completed on CIMHA ☐		*Comments:*			
Individual Care Plan	Completed ☐	Uploaded on CIMHA ☐	*Comments:*			
Recovery & Relapse Prevention Plan	Consumer Completed ☐	Reviewed - No changes ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐		
Strengths Assessment Tool	Completed ☐	Reviewed - No changes ☐	Allied Person Input ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	
HoNOS	Completed ☐	Entered on CIMHA ☐				
Life Skills Profile (LSP)	Completed ☐	Entered on CIMHA ☐				
Mental Health Inventory (MHI)	Consumer Completed ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	Entered on CIMHA ☐		
Involuntary Patient Summary (IPS)	Completed on CIMHA ☐	Sent to Medical Services ☐	N/A ☐			
Allied Person	Completed ☐	Sent to Medical Services ☐	Reviewed - No changes ☐	N/A ☐		
Drug Check, Audit & Problem List	Completed on CIMHA ☐	Reviewed - No changes ☐	N/A ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	
Consent to Carer/Family/Friend Involvement	Consumer Completed ☐	Copy to Clinical Initiatives Coordinator ☐	Reviewed - No changes ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	
Consumer Participation Action Plan	Completed ☐	Reviewed - No changes ☐	N/A ☐	Consumer Refused ☐	Unable to complete due to Mental State ☐	
Crisis Intervention Plan (CIP)	Completed on CIMHA ☐	Copy to DILO & AH NM ☐	Reviewed - No changes ☐	N/A ☐		
Inter Service Communication Plan	Completed & uploaded to CIMHA ☐	Copy to DILO & AH NM ☐	Reviewed - No changes ☐	N/A ☐		
Child Protection Form	Completed on CIMHA ☐	Printed & submitted for filing ☐	N/A ☐			
Other Assessments/Clinical Area Tools *eg LCT, HCR-20, QPS Escort Assistance Form, Allied Health reports*						
Clinical Chart Audit	Completed ☐					

Appendix B

INDIVIDUAL CARE PLAN (ICP)

The Park – Centre for Mental Health

Patient ID Label

CONSUMER PROFILE

	Name	*Signature*	
Consumer:	Mike Leggings		**Date Completed:** 30/7/2013
Care Coordinator:	Johnny C. Lately		**Review Date:** 1/8/2013
Assoc. Care Coordinator:	Anna Conda		**Approximate MHRT Date** - 13/9/2013
Authorised Doctor:	Bill Watermaucse		

Note: The ICP must be signed by the Authorised Doctor to comply with the MHA2000. When signed by an Authorised Doctor, this form replaces the MHA2000 Treatment Plan Form.

Regular assessment to be conducted by the authorised psychiatrist (*state the intervals in days or weeks*): 6 weekly

- ☒ **ICP discussed with consumer**
- ☒ **Consumer given copy of ICP**
- ☐ **Consumer attended Team Meeting**
- ☐ **Unable to discuss with consumer due to:**

Significant Progress/Setbacks for the consumer over the last 3 months (*including medication changes, PRIME Incidents, seclusion, engagement in structured day, leave etc*):

- Michael continues to have auditory hallucinations, some of which are distressing and others he finds comforting or amusing.
- Expresses anxiety over financial matters, keeping his flat, and fear of neighbours stealing property (?delusional)..
- Some agitation over past 3 months; two incidents of requesting time in comfort room
- Disorganised thinking, poor concentration and attention.
- Medication:

Olanzipine 10mg nocte
Alprazalam 1mg PRN

Diagnosis: Schizophrenia, unspecified F20.9

Mental Health Act 2000 Status:

☐ Voluntary ☐ ITO ☒ Forensic ☐ SNFP
☐ Classified ☐ Chap 7 (part 2)

Current Limited Community Treatment (*currently accessing*):

☐ Escorted Campus Leave ☐ Unescorted Campus Leave ☐ None
☐ Escorted Ground Leave ☐ Unescorted Ground Leave
☐ Escorted Off-Ground Leave ☐ Unescorted Off-Ground Leave ☒ Overnight Leave

Has a ***Crisis Intervention Plan (CIP)*** and/or ***Inter-Service Communication Plan*** been completed in conjunction with the Forensic Liaison Officer (FLO)?

CIP: ☒ Yes ☐ No ☐ Not Required
ISCP: ☐ Yes ☐ No ☒ Not Required

Does this consumer have active **alerts** in place?

☐ Yes ☒ No ☐ Has alert been entered/reviewed on CIMHA?

Maintaining Mental Health: Managing Symptoms, Recognising Signs of Becoming Unwell, Risk Assessment & Management Plan

Has the consumer completed a *Strengths Assessment* ? ☒Yes ☐ No	Has seclusion and/or restraint been used with this consumer? ☒Yes ☐ No
Has the consumer completed a *Consumer Participation Action Plan* ? ☐Yes ☒ No	Has a *Trauma Restraint and Seclusion Tool* been completed? ☒Yes ☐ No
	Has a *Seclusion Episode Form* been completed? ☒Yes ☐ No
Consumer's Goal Statement: I want to learn how to relax and stop the jitters when they happen.	**Summary of Current Issues:** Troubled by auditory hallucinations (the male voice he calls "my uncle" telling him he's worthless). High levels of anxiety. Restlessness, poor concentration, disorganised thoughts. Previous aggression. See psychologist report 22/6/13.

HoNOS Scores	1	2	2	0	4	2	6	3	7	0	8	2	LSP Scores	7	0	10	2	11	1	12	1	14	1	15	1

Areas to consider: Psycho education, Consumer's coping strategies, Managing medication side effects, Psychological interventions, Counselling, Relaxation techniques, restrictive practices.
Refer to Consumer Strengths Assessment, Risk Screening Tools & Management Plans, Behaviour Management Plans, Psychologist Assessments, HCR20

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Try three different relaxation techniques to use when Mike is feeling anxious.	I will find out about different techniques and choose 3 to try. Learn and practice techniques, one at a time.	Provide information and training for relaxation techniques. Support and encourage Mike in practicing relaxation. Help Mike identify which techniques work best, and why. CBT approaches to be tried through weekly sessions.	Psychologist, rehab staff. All staff. Psychologist, CC, rehab staff. Psychologist	1/10/13
Chart the use of PRN medication for anxiety.	Mike will record his mood and triggers for when he requests PRN medication.	Record symptoms, triggers and other factors when PRN medication given on PRN Chart.	Nursing staff	1/10/13
Continue with medication regime and monitoring side effects.	Take medication as prescribed. Tell staff about any concerns or changes.	Administer medication as prescribed and monitor side effects, particularly weight gain.	Medical & nursing staff.	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. medications, psycho-social interventions, risk management strategies

Strategy	Did it work? Provide details	Date Attempted/Implemented
Use distractions when Mike is disturbed by voices.	Using music and TV as distractions worked well, and talking reassuringly to Mike. Playing cards or games does not work effectively, as Mike is unable to concentrate.	Commenced May 2013 Continue as required.

HoNOS: 1- Overactive, aggressive, disruptive or agitated; 2- Non-accidental self injury. 4- Cognitive problems; 6- Problems with Hallucinations/Delusions; 7- Problems with Depressed Mood; 8- Other mental/behavioural problems
LSP: 7- Violence to others; 10- Medication reliability/compliance; 11- Willingness to take medication; 12- Co-operation with health workers 14- Offensive behaviour; 15- Irresponsible behaviour.

Physical health, Nutrition & ADL's: Weight, Diet, Physical Co-morbidities, Self Care, Hygiene.

Height 179 cm	Weight: 82 kg Date: 1/8/13	BMI: 25.5 Date: 1/8/13	Waist Circumference: 92 cm Date: 1/8/13	Weight Hx (inc dates): Has put on 5kg in approx 6 months. Stable at 77kg 2011-2012.

Consumer's Goal Statement: I'd like to feel fit again. My black jeans are too tight.	**Summary of Current Issues** *(inc physical co morbidities)*: Recent weight gain. Lack of physical activity. Issues with hygiene and self care – recurrent skin and fungal infections.

HoNOS scores	5	1	10	2		LSP scores	4	2	5	1	6	2	9	0			

Areas to consider: Fasting Glucose, Cholesterol (HDL-C, LDL-C) Triglycerides, Blood Pressure, Behavioural Therapy Strategies, Lifestyle/Activity Changes, Dietary Modifications, Support Services (eg Lifestyle Clinic, Dietetic Services, Diabetes Clinic), Self Care, Hygiene, Infectious Diseases, Disabilities, Acute and Chronic Conditions
Refer to Metabolic Management Action Plan, Weight & Obesity Management Action Plan, Rehab Progress Reports, Lifestyle Clinic Report

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Attend Lifestyle Clinic through GHS	Attend appointments. Attempt changes to diet & activity as suggested by dietician.	Remind of appointments. Advise on specific goals and strategies for Mike. Support lifestyle changes. Monitor physical health & weight.	Nursing staff. Dietitican & GHS All staff. Nursing staff & CC.	1/10/13
Mike will engage in at least one physical group activity each week.	I will choose a sporting or moving activity to attend each week (eg walking, swimming).	Encourage and support Mike to attend rehab activities on offer. Ask Mike specifically when activities are being run.	All staff. Rehab team	1/10/13
Improve hygiene and skin care.	I will have a shower every day and put the cream on my skin morning and night.	Prompt Mike to shower and apply antifungal ointment. Assist if necessary. Prompt Mike to change clothes regularly.	Nursing staff & CC	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. diet, exercise programs, education, clinical interventions

Strategy	Did it work? Provide details	Date Attempted/Implemented

HoNos5- Physical Illness or Disability. 10- Problems with ADL's
LSP: 4- Personal grooming; 5- Clean clothes 6- Neglect of physical health. 9 does this person generally maintain an adequate diet

Substance Misuse: Drugs, Tobacco, Alcohol & Other Harmful Substances.

☒ *Drug Check & Audit* Completed on CIMHA Date: 1/08/2013 Substance Misuse Problem identified ☒Yes ☐ No	☒ *Readiness to Change Questionnaire* Completed/Reviewed Date: 1/08/13 ☒ *Smoking Cessation Pathway* Completed Date: 1/08/13
Consumer's Goal Statement: I want to stop smoking forever	**Summary of Current Issues:** Was a heavy smoker (40 a day) but has been successfully using inhaler & patches to cease smoking. Occasional drug use when on leave.

HoNOS Scores	3	3	LSP Scores	6	2

Areas to consider: Motivational Interviewing, ATODs Support, MAISE Program, Psycho education Programs
Refer to Drug Check & Audit, Readiness to Change model, D&A Pathway

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Start decreasing use of Nicotine Replacement Therapies.	Reduce daily use of inhaler. Continue to wear NRT patches.	Encourage use of inhaler as PRN only.	Nursing staff	1/10/13
Routine UDS to be completed when return from overnight leave as per LCT conditions	I will not use drugs while on leave & cooperate with UDS on return.	Administer UDS when consumer returns from leave.	Nursing staff	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. education programs, nicotine replacement strategies etc

Strategy	Did it work? Provide details	Date Attempted/Implemented
Attended MAISE rehabilitation program	Helped Mike understand his recreational drug use. Mike has avoided situations likely to lead to drug use while on LCT.	April 2013

HoNos: 3- Problem drinking or drug taking LSP: 6- Neglect of physical health.

Daily Living Situation/Financial/Vocational/Educational: Current & Future Accommodation, Money Management, Qualifications, Ambitions

Finances	☐ Capable	☒ Incapable	☒ Public Trustee	☐ Family (give details)	☐ Waiver type:

Consumer's Goal Statement:	Summary of Current Issues:
I want to live in a flat with my brother Frank. I would like to work as an accountant one day, because I like numbers and money.	Limited budgeting and money management skills, mostly due to impulsiveness (has good numeracy skills). Previously lived with brother, though concerns regarding influence in illicit drug use and peer group. See Strengths Ax and Occupational therapy report (2/6/13).

HoNOS scores	11	2	12	3	LSP scores	13	2	16	3

Areas to consider: Trust Agreements, Money Management, Volunteer work, Vocational Training Programs, HASP, Transitional Housing, CCU relocation, Self-care skills, Shopping, Driving, Community access/use of public transport, Food preparation skills, Housekeeping, Time management, Laundry, Use of a mobile phone / public phone/land line phone, Medication management, Caring for a child or pet

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Use LCT opportunities to plan and practice money management.	I will find out how much things cost, like going to the movies, and save for them.	Identify ways of budgeting with Mike. Use tools from the Money Management programs to assist.	CC, rehab staff and OT	1/10/13
Explore Mike's interest in accounting and bookkeeping.	I will talk to my dad's mate, John, who's an accountant. I'll borrow books from the library about bookkeeping and look it up on the internet.	Provide opportunities for Mike to find information, eg trips to library & supervised internet access. Support Mike in understanding this information.	CC. rehab staff and OT	1/10/13
Explore feasibility of living with brother Frank.	I will ask Frank to come and talk with the team, and if he doesn't mind me living with him again.	Arrange meetings with family (brother, sister, and mother) to discuss concerns and options for living arrangements in future (inc. access to drugs).	Social worker	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)

e.g. course attendance, work programs, accommodation options

Strategy	Did it work? Provide details	Date Attempted/Implemented
Undertake Money Management program	Mike completed the 8-week program, and showed good skills in calculating, but limited skills in knowing how much things cost and budgeting for daily living costs.	Completed February 2013
Started ACE course in using Microsoft Excel and Word	Mike's mental state declined after the second week of the course, and did not complete it.	Attempted June 2012.

HoNos: 11- Problems with living conditions, 12- Problems with occupation and activities. LSP: 13- Problems with others in the household. 16- Type of work is this person capable of performing.

Social Supports/Spirituality: Community Support, Family, Friends, Church, Spiritual & Cultural Needs.

Allied Person: ☒ Yes Name: Anne Leggings ☐ No – yet to be specified ☐ Not Applicable	**Guardianship Order:** ☐ Yes ☒ No If yes, what is the nature of the order:
Has this care plan been discussed with the Carer? ☒ Yes ☐ No Has a *Consent to Carer/Family/Friend Involvement in Care* Form been completed? ☒ Yes ☐ No Does the Consumer come from a CALD background? ☒ Yes ☐ No If yes, is the Cultural Mental Health Worker engaged? ☐ Yes ☒ No Has the ATSI Liaison Officer been engaged? ☐ Yes ☐ No ☒ N/A	Has the *Cultural Diversity Assessment Checklist* been completed? ☒ Yes ☐ No Are there other External Agencies/NGO's engaged? ☐ Yes ☒ No If yes, provide details: Has the family been referred to the Rehabilitation Social Worker for a single session family support program? ☒ Yes ☐ No
Consumer's Goal Statement: I'd like to follow my faith and find out more about Judaism. I want to make friends who won't push me back into drugs. I'd like to have a girlfriend.	**Summary of Current Issues:** Mike's mother is from Israel and follows the Jewish faith. Mike followed Judaism and learnt some Hebrew as a boy, and has recently shown interest again. Mike has no close friends, apart from 'party' acquaintances who took drugs. Mike has lost a lot of money in the past by giving it to 'friends' who then spent it on alcohol and drugs.

HoNOS scores	9	2		LSP scores	1	2	2	0	3	1	8	3

Areas to consider: Strengths Assessment, NGO engagement, Family engagement, How does the person keep in touch with family & other support networks?

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Arrange weekly contact with the Brisbane Jewish youth group.	I will attend the Jewish youth group every week, and will try to make friends their. I will talk to the Rabbi when I'm feeling lost spiritually.	Enable LCT for Mike to attend youth group. Provide opportunities for Mike to discuss the group, and practice social skills and developing friendships.	CC, all staff.	1/10/13
Practice social skills during weekly BBQs.	I will try to have a conversation with someone different every week. I'll practice the things that I learn with the staff.	Encourage Mike to have conversations with others. Prompt Mike with techniques, ideas for topics & openers, avoiding distraction of voices, etc.	CC, All staff CC, all staff.	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. linkages with community, family visits, church attendance

Strategy	Did it work? Provide details	Date Attempted/Implemented
Attended 8-week Social Skills Training rehab program	Mike gained some insight into issues with drug-using acquaintances. Practiced assertiveness, which he has used to some success on the ward (eg refusing to give money to others when he doesn't want to).	Completed program in March 2012

HoNOS: 9- Problems with relationships; LSP: 1- Difficulty responding to conversation; 2- withdraw from social contact; 3- show warmth to others; 8- make/keep friendships.

Leisure/Recreational: Interests, Hobbies, Sporting Activities

Consumer's Goal Statement:	Summary of Current Issues:
I'd like to go to Punt Road in Melbourne one day and meet the Richmond Tigers (AFL team). I'd like to go to a live footy game again. I want to go to the movies more often.	Mike is an avid fan of the Richmond Tigers AFL team, and follows the games each week (watches them if they are televised). Mike used to play team AFL. Not currently engaged in any sporting or physical activity. Enjoys singing and some other group activities.

HoNOS scores	12	3	LSP scores	2	0

Areas to consider: Strengths Assessment
Refer to Participation in Structured Day activities

Strategies	Consumer Actions	Support Role/Treatments	Team Members Responsible *(including Clinicians, Carers, NGO's etc)*	Review Date
Use money management strategies to plan 2 trips to the movies in the next 3 months.	I will check my spending and make sure I have money saved to go to the movies. I will check the newspaper for movies and times I'd like to go.	Encourage Mike to avoid impulsive spending. Provide support to plan movie trips (eg finding section in newspaper, discussing movie reviews). Provide LCT opportunities and staff to attend.	CC & A/CC Clinical team, rehab team.	1/10/13
Practice football skills at least once a week (see goals in Physical Health section)	I will ask for the footy and have a kick around the yard with the guys at least every Monday.	Provide football and opportunities to practice. Encourage activity. Refer to exercise physiologist for physical assessment and exercise tips.	Nursing and Rehab staff. CC & exercise physiologist.	1/10/13

Strategies that have worked/didn't work in the past (Progress of Care)
e.g. attendance at Diversional Activities, Groups, Outings

Strategy	Did it work? Provide details	Date Attempted/Implemented

HoNOS: 12- Problems with occupation and activities. LSP: 2- withdraw from social contact

Recovery & Relapse Prevention Plan: How can I stay well & avoid crisis? What can I & others do to help when I am feeling stressed?

What I am like when I am feeling alright & well:	I like singing and talking to others when I'm well. I used to sing to myself a lot. I want other people's company when I'm feeling good.
Things I need to do to keep me feeling well:	I need to take my medication. I need to keep busy and find things to occupy my mind and body. I need to listen to music when the voices get annoying.
Things that cause me stress. Are there people, places or things to avoid?	I don't like shopping centres when I'm jittery. I don't like the noisy food courts. I don't like being on the ward when the other patients are noisy or angry.
Things I might notice when I am getting stressed:	I get jittery and restless – can't stay still. I feel all squirmy inside, and my head gets either all stuffed up or has the voices getting angry.
Things others might notice when I'm starting to get stressed:	My legs bouncing up and down. I walk up and down a lot. Sometimes I hold my head, or talk to the voices.
Ways I can calm myself or make myself feel better when I'm stressed:	Go to the comfort room. Listen to my music. I want to try some relaxation stuff.
Things others can do to make me feel calmer or safer when I'm stressed:	Give me ideas of ways to relax. Walk with me when I'm pacing. Tell me that the voices aren't real. I like when Johnny says "you're stronger than your uncle" when his voice gets annoying.
People who support me and I trust to help me when I'm feeling stressed:	Johnny, my care coordinator. My mum. Jenny, the nurse on night shift.
Things that make it more difficult for me when I'm feeling stressed:	Not being able to go to the comfort room. When I can't get away from the noises.

Consumer Signature:	Date Implemented:	Date Reviewed with Consumer:
Mike Leggings	12/6/2012	30/7/2013

Appendix C

Queensland Government
Queensland Health
The Park – Centre for Mental Health

CONSUMER STRENGTHS ASSESSMENT

Complete Details or Affix Patient Label

Name...Michael Leggings..... Gender. M /F

Address .....

.....

Phone... .....Mob.....

Date of Birth 23/ 8 /1984 U.R. .....

	Present Moment What are my current strengths? What am I doing now?	Future Desires, aspirations What do I want?	Past Resources – personal, social What have I used in the past?
Mental Health	I use the comfort room when I'm jittery or the voices are annoying. I listen to my music when I'm anxious. I take my medication. I hear some nice voices that make me laugh sometimes.	I want to learn how to relax and stop the jitters when they happen.	Used PRN medication. Avoided stressful places and people. I stayed out of hospital for 9 months.
Physical Health, Nutrition, ADL's	I like to eat good food, and I love fruit and vegies. I have pretty good health, and I don't get sick very often.	I want to feel fit again. My black jeans are too tight. I want to get rid of my smoker's cough in the morning.	Learned to control my asthma when I was a kid. Don't get that anymore. I had a GP that I liked. I was a vegetarian for a while. I used to play AFL that kept me fit.
Daily Living Situation/Financial	I get enough money through my pension to get by. I have somewhere to go when I'm on leave – my brother's place, or my mum's. I can cook and look after a place.	I want to live in a flat with my brother Frank.	I'm pretty good at cooking and housekeeping. I used to live with my brother, after I moved out of mum's place. I usually paid my bills and rent on time, before I got sick the first time.
Vocational/ Educational	I'm good at maths. I like numbers and money. I'm pretty good at using computers.	I would like to work as an accountant one day. I'd like to do some more computer courses.	I got good grades in High School for maths and science. I've had jobs at McDonalds, McGills Bookstore, did some book keeping and reception work for my dad's smash repairs shop. I liked paper work.

Social Supports/ Spirituality	I have my mum and brother, who talk to me a lot and look after me. I am Jewish. I like a lot of the traditions and beliefs. I know a lot of people on the ward and outside.	I'd like to follow my faith and find out more about Judaism. I want to make friends who won't push me back into drugs. I'd like to have a girlfriend.	My mum's Jewish and taught us a lot. I used to know some Hebrew. I had lots of party friends. They liked me because I shared and gave them money. I had a girlfriend in high school.
Leisure/ Recreational	I love the AFL, and go for the Richmond Tigers. Wish they did better. My favourite colours are yellow and black! I'm a good singer. I like listening to music. When I'm happy I like listening to dance & techno. When I'm jittery, I listen to Llor. I like his lyrics. I like movies, especially action and sci-fi.	I'd like to go to Punt Rd in Melbourne and meet the Richmond Tigers. I'd like to go to a live footy game again. I want to go to the movies more often.	I used to play AFL when I was in high school. I used to go to the games, especially when Richmond played in Brisbane. I used to have fun at parties and raves. I liked to get high.
Personal Qualities: Generous; honest; I can be funny sometimes. I'm pretty deep.			
What are my priorities: 1. Learn how to relax & stop the jitters 2. Follow my Jewish faith 3. Go to the movies more often.			

J. C. Lately	Michael Leggings
Care Coordinator signature	Consumer signature
Date Started: 8/3/13	Date Reviewed: 30/7/13
	Date Reviewed:
	Date Reviewed:
	Date Reviewed:

Appendix D

Queensland Government Mental Health Services **Risk Screening Tool** Facility:	(Affix identification label here) URN: Family name: Given name(s): Address: Date of birth: Sex: ☐ M ☐ F ☐ I

Date:	Time:

Suicide / self harm

Static factors
- ☐ Previous serious attempt
- ☐ History of self harm
- ☐ History of suicide attempt
- ☐ Family history of suicide
- ☐ Long-standing problems (e.g. unemployment, physical illness / pain, mental disorder)

Dynamic factors
- ☐ Intent / plan / thoughts
- ☐ Current suicide attempt
- ☐ Distress / anger
- ☐ Isolated / lonely
- ☐ Hopelessness / perceived lack of control over life
- ☐ Stressors in last 6 months
- ☐ Psychotic symptoms (e.g. command hallucinations)
- ☐ Other: ....

Violence (including sexual violence)

Static factors
- ☐ Under 25 years of age
- ☐ Conduct disorder
- ☐ History of violence / sexual offence / criminal history
- ☐ History of substance abuse

Dynamic factors
- ☐ Impulsivity
- ☐ Anger
- ☐ Intoxication / withdrawal
- ☐ Cognitions supporting violence
- ☐ Carries weapon / access to firearm
- ☐ Recent threats or other aggressive actions / thoughts
- ☐ At risk of sexually abusing others
- ☐ Psychotic symptoms (command hallucinations, threat-control-override and misidentification symptoms, morbid jealousy)

Vulnerability
- ☐ At risk of being sexually abused by others
- ☐ At risk of domestic / family violence
- ☐ At risk of being financially abused by others
- ☐ Deep Vein Thrombosis (DVT) risk
- ☐ Skin integrity risk
- ☐ At risk of being financially abusive to others
- ☐ At risk of self neglect (basic ADLs, complex living skills)
- ☐ Cognitive impairment / intellectual disability
- ☐ Fire risk
- ☐ Falls risk

Absence without approval
- ☐ History of absconding
- ☐ History of Limited Community Treatment breach
- ☐ Treatment refusal
- ☐ Frustration regarding hospitalisation / involuntary treatment

Clinician's name (please print):	Designation:	Signature:	Team:	Date:	Time:

Page 1 of 2

DO NOT WRITE IN THIS BINDING MARGIN

MHS - RISK SCREENING TOOL

v2.00 - 03/2012 SW201

Queensland Government

Mental Health Services

Risk Screening Tool

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐M ☐F ☐I

Child protection risk screen

Does the consumer have custody or care responsibilities for children (full time or periodic)? ☐Yes ☐No

If yes, the *Mental Health Child Protection form (SW188)* must be completed.

Completed by (print name):	Designation:	Signature:	Date:

Clinical risk formulation / assessment summary (precipitating / responsible factors that have precipitated current admission / situation / risk behaviour; factors perpetuating risk and protective factors reducing the risk)

Overall risk summary	Low	Medium	High	Unknown	Comments regarding risk
Suicide	☐	☐	☐	☐	
Other self harm	☐	☐	☐	☐	
Aggression	☐	☐	☐	☐	
Vulnerability	☐	☐	☐	☐	
Absconding	☐	☐	☐	☐	
Dependent children / others?	☐ Yes		☐ No	☐	

Is further risk assessment required? ☐ Yes (if yes, consider full assessment) ☐ No

Clinician's name (please print):	Designation:	Signature:	Team:	Date:	Time:

DO NOT WRITE IN THIS BINDING MARGIN

Appendix E

Queensland Government
Queensland Health

WEST MORETON SOUTH BURNETT HEALTH SERVICE DISTRICT
THE PARK – CENTRE FOR MENTAL HEALTH

(please affix patient label here)
UR Number: xxxxxx
Surname: Leggings
Given Names Michael Richard
Date of Birth: 24/8/1984 Sex: F ☐ M ☒

CONSENT TO CARER/FAMILY/FRIEND INVOLVEMENT IN CARE

This form provides you with an opportunity to record who you want to be involved in your care. This form will be kept in your clinical file to ensure all members of the treating team are aware of your wishes. Remember, at any time you can change your decision regarding who you wish to be involved in your care and to what extent.

Please note that it is important that you have read and understood the leaflet **"Carers, Family and Friends - Involvement In Care"** before completing this form. If you have not read this leaflet please talk to the Social Worker or your Care Coordinator.

Please tick the relevant box:

☒ Yes, I give consent for the below listed carer/family member/friend(s) to be involved in my care, as specified in my care plan.

Name	Address	Phone Number	Relationship
Annie Leggings	1 Peg Avenue, Johnson Creek Qld 4321	07 5432 1098	Mother
Frank Leggings	Unit 2/26 Wild Street, Juneberry Q 4567	0404 050 060	Brother

☐ No, I do not give consent for my carer/family member/friend(s) to be involved in my care but understand you may share general information with them regarding The Park, mental illness etc.

☐ No, I do not give consent for my carer/family member/friend(s) to be involved in my care and I do not wish them to know that I am being treated at The Park.

Other Special Considerations (eg relationship history, legal issues)
Michael has previously been acquainted with people who were drug users and dealers. He does not wish to have contact from Mr John Ferner or Miss Jane Olden, and does not want them to know of his whereabouts or treatment.

Consumer	*Michael Leggings*		8/4/09
	(Signature)		(Date)
Witness (Staff Member)	J.C. Lately	R.N.	8/4/09
	(Signature)	(Position)	(Date)

- Please send a copy of this form to the Clinical Initiatives Coordinator (Administration Building)
- This form is to be filed in the clinical record behind the 'Individual Treatment Plan' divider.
- Please destroy any superseded versions of this form.

CONSENT TO CARER/FAMILY/FRIEND INVOLVEMENT IN CARE

G:\Everyone\Health Information Services\HIM Forms\Individual treatment forms\Consent Involvement In Care

Appendix F

The Park – Centre for Mental Health
Consumer Information Sheet

Carers, Family and Friends - Involvement in Care

When people are in hospital, often they have family or friends who worry about them and would like to know how they are. Family and friends can be important supports in a person's journey towards recovery.

Some people choose to involve their families, carers or friends in all parts of their care at The Park. Some like them to know a bit. Others prefer them not to be involved in their care at all. This is a choice we would like each person to make.

You might like to think about how you want your family, carers or friends to be involved in your care, while you are here. Some questions you might want to consider are:

- How much you want them to know about your care at The Park
- How much they can take part in decision making with you & the treating team
- If you would like them to stand up for your rights and preferences
- If you would like them to attend Mental Health Review Tribunal hearings with you, or for you (eg speak on your behalf).
- If you would like them to talk to the treating team, and how often.
- If you would like them to help you out in other ways, eg emotional, social, financial support.

It is important that your Care Coordinator knows about your wishes. Then they can record it so all treating team members know.

If you decide that you don't wish certain people to be involved in your care at all, it is important for us to understand this. The treating team highly value maintaining your privacy. Any personal or clinical details that you wish to keep private will not be shared with your carers, family or friends. However, in very rare cases such as an emergency, clinical staff may need to disclose limited information to your family, for example, in a medical emergency or if you are absent without permission.

Family members also have the right to information about mental illness, and other things that may affect them. If your family know that you are receiving care from us, we may share general information with them. This information may include:

- General information about The Park.
- General information about mental illness (we won't disclose your diagnosis if you don't want us to).
- Updates about news in the mental health field, eg research, workshops, events.
- Useful resources and support for carers.

We ask that you indicate your wishes in relation to these matters on a consent form. At any time you can change your decision regarding who you wish to be involved in your care and to what extent. Simply talk to your Care Coordinator.

If you have any questions about this information sheet or the consent form, please talk to your Care Coordinator, Social Worker, the Consumer Advocate or Consumer Consultant.

Attachment 3

The Park Centre for Mental Health

INDIVIDUAL CARE PLAN CHECKLIST - Adolescent -

Affix Patient ID Label Here

- The tools listed below are the required documents that make up the Care Planning Package. These tools need to be **reviewed every three months.** There may be additional tools that are specific to clinical areas or specific patients.
- Indicate in the tick box if each assessment has been completed. If not completed for any reason (eg consumer refusal, consumer unavailable) write the reason in the space below the tick box.
- Ensure all documentation is signed by relevant parties (i.e. Care Coordinator, Doctor & Consumer where possible)

		Date: / /	/ /	/ /	/ /
		Review type: New episode ☐ Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐	Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐	Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐	Standard Review ☐ Ad Hoc Review ☐ End of Episode ☐
Risk	Risk Assessment Profiles:	Aggression / Rating; Self Harm; Absconding	Aggression / Rating; Self Harm; Absconding	Aggression / Rating; Self Harm; Absconding	Aggression / Rating; Self Harm; Absconding
Care	ICW Progress Summary Notes	☐	☐	☐	☐
Recovery Plan	Individual Care Plan	☐	☐	☐	☐
Recovery Plan	Crisis Intervention Plan	☐	☐	☐	☐
Recovery Plan	Relapse Prevention Plan	☐	☐	☐	☐
Health Outcomes Scales	Health of the Nation Outcome Scales for Children & Adolescents (HoNOSCA)	☐	☐	☐	☐
Health Outcomes Scales	Children's Global Assessment Scale (CGAS)	☐	☐	☐	☐
Health Outcomes Scales	Factors Influencing Health Status (FIHS)	☐	☐	☐	☐
Health Outcomes Scales	Strengths & Difficulties Quest. (SDQ)	Parent ☐ Adolescent ☐ Teacher ☐	Parent ☐ Adolescent ☐ Teacher ☐	Parent ☐ Adolescent ☐ Teacher ☐	Parent ☐ Adolescent ☐ Teacher ☐
Consumer Tools	Consumer Participation Action Plan	☐	☐	☐	☐
Consumer Tools	Strengths Assessment Tool	☐	☐	☐	☐
Consumer Tools	Consumer Developmental Tasks Questionnaire	☐	☐	☐	☐
MHA	Involuntary / Voluntary Status	Voluntary ☐ Involuntary ☐	Voluntary ☐ Involuntary ☐	Voluntary ☐ Involuntary ☐	Voluntary ☐ Involuntary ☐
MHA	Involuntary Patient Summary (IPS)	☐	☐	☐	☐
	Other Assessments/Clinical Area Tools: *eg. Child Protection Form, LCT, HCR-20*				
Audit	Clinical Chart Audit	☐	☐	☐	☐

Attachment 4

The Park - Centre for Mental Health
Treatment, Research and Education

Together... Towards Recovery

The Barrett Adolescent Centre

Information for Teenagers

Reviewed: 08.09.06

Your rights and responsibilities (continued)

Before you agree to treatment you have a right to:

- have your condition explained in terms you will understand
- know and understand your treatment options
- know how the treatment will affect you
- be able to seek another opinion where this is possible

While you are at the Centre your responsibilities include:

- Everyone respects property, people and individuality
- We value people's safety
- We encourage optimum participation and involvement

THE TYPE OF HELP OFFERED AT BARRETT

Coming to Barrett Adolescent Centre offers help because of several factors:

- experienced, professional staff (eg. What staff will look after me? ...Case Coordinator)
- educational and life skills programs to restore confidence in many areas of teenage life
- a range of recognised therapies
- living and learning with a group of other teenagers
- within an environment comfortable to adolescents.

What staff will look after me?

During your stay you will be cared for by a team including psychiatrists, nurses, social worker, psychologists, speech pathologist, occupational therapists, dieticians, teachers, leisure therapist and others such as clerical, catering and housekeeping staff. All staff wear photographic identity badges including name, photograph and job title.

Case Coordinator

Following admission, adolescents will be assigned a nurse who will be their Case Coordinator. The Case Coordinator will maintain close contact with the adolescent and will oversee all aspects of an adolescent's treatment as decided by the Treatment Team. The Case Coordinator is the primary contact for the adolescent, their family/carers and significant others.

Individual Therapist

All adolescents are assigned an Individual Therapist who is usually a psychologist.

This staff member engages adolescents in therapeutic one-to-one counselling on a weekly basis. These sessions are confidential between the adolescent and therapist.

Family Meeting .

Depending on individual needs adolescents and their families may be involved in family therapy sessions.

A Family Therapist will be assigned for an adolescent (as required) and the Case Coordinator will work closely with this person to run therapy sessions.

Attachment 5

The Park - Centre for Mental Health
Treatment, Research and Education

Together... Towards Recovery

The Barrett Adolescent Centre

Information for Parents and Carers

Queensland Government

Queensland Health

Reviewed: 08.09.06

Prior to an adolescent being admitted to the Barrett Adolescent Centre their parents or carers often ask:

What happens at the Centre?
What do they need to bring?
Who should I talk to?
When can I visit?
and many other similar questions

This booklet has been written to give you some initial answers to these questions and to help you understand more about what happens at the Barrett Adolescent Centre.

If you have any other questions, please do not hesitate to give the Centre a call and one of our staff will be able to help.

We want you and your family to feel more comfortable with accessing our service. We look forward to working with you to bring about the best possible outcome for your adolescent.

WHAT IS THE BARRETT ADOLESCENT CENTRE?

The Barrett Adolescent Centre is a specialised centre situated in the pleasant grounds of The Park - Centre for Mental Health Treatment, Research and Education, at Wacol.

It is the only extended treatment and rehabilitation mental health centre for adolescents in Queensland.

Our mission is ***"to work together with adolescents, their parents or carers and our other partners to provide effective mental health interventions integrated with education and life skills programs that support teenagers in their journey towards recovery"***. For this reason we encourage contact by family members and most adolescents spend their weekends at home following the initial assessment phase of their admission.

The Centre also has a school that caters to the individual's academic needs.

The Centre program is designed to assess and treat adolescents with complex mental health problems. These include depression, schizophrenia, anxiety disorders and anorexia just to name a few.

Admissions may be for a limited assessment period, a longer stay treatment program, or attendance as a day patient. The therapeutic programs include group therapy, individual therapy, family therapy, adventure therapy, psychological assessment, continued education and a life skills program.

Our aim is to bring about suitable improvement in your adolescent's wellbeing, such that other forms of community treatment will be successful following discharge.

WHO CAN I TALK TO?

Prior to your adolescent's admission, our Clinical Liaison Person (Intake Nurse) will be in contact with you. This is the person who sent you this booklet. They will be there when your adolescent is admitted. You are welcome to call this person during normal office hours on **3271 8742** and ask to be put through to him/her.

Following admission, your adolescent will be assigned a nurse who will be their Case Coordinator. This nurse will oversee all aspects of your adolescent's treatment as decided by the treatment team. The Case Coordinator will work very closely with your adolescent to establish treatment goals and coordinate the implementation of treatment programs. It is important to maintain very regular contact with this person to discuss your adolescent's treatment. Nurses work shifts and can be contacted on either **3271 8760** or **3271 8761**.

Whenever your adolescent's Case Coordinator is not on duty, you may call and ask for the Clinical Nurse on duty, using these same numbers. They will be able to answer your enquiries.

Throughout their stay, your adolescent will receive treatment from a variety of our multidisciplinary team members. The Treatment Team includes consultant psychiatrist, psychiatry registrar, nursing staff, psychologist, occupational therapist, speech pathologist, social worker, dietitian, teachers, social worker and leisure therapist.

The psychologist works in collaboration with adolescents to develop psychological and behavioural interventions that can be used to help manage problems such as depression, anxiety, anger and poor coping and social skills. The psychologist works with the adolescent in tailoring these to the individual's specific requirements. Some individuals may also require assessment of cognitive functioning, which the psychologist will conduct as part of a comprehensive assessment.

Depending on individual needs, the social worker will work with adolescents and/or significant others to help find other ways of approaching their problems and to plan effective action in areas such as individual casework, family meetings, group work, linking to community organisations, money management, education/schooling, cultural issues, activities of daily living, sports and recreation, and accommodation.

Your adolescent will also have an Individual Therapist who is usually a psychologist. This staff member engages your adolescent in a therapeutic relationship involving one-to-one counselling on a weekly basis. These sessions are confidential between the adolescent and the therapist. Adolescents feel free to open up more in therapy when they know their therapist only talks to them.

For this reason it is preferred that parents do not have contact with the Individual Therapist. Your adolescent's Case Coordinator will be able to advise you on what general topics are being discussed in therapy.

Depending on individual need, teenagers may also be involved in speech pathology sessions. The speech pathologist assists adolescents with communication skills. This can involve assessment, treatment in individual sessions, or group work.

The occupational therapist works with all adolescents to help increase their independence and confidence in daily activities eg self-care, home duties, being a friend, studying, working, and doing leisure, religious and cultural activities.

Developing skills to complete these activities is important for survival, giving meaning to life, contributing to one's sense of self, and promoting health and recovery. Occupational therapy may include assessment, individual therapy, parent/carer consultation, and group work.

The dietitian may also see your adolescent. The dietitian will assist them in ensuring that their nutritional requirements are met and any nutritional or eating issues are addressed.

All adolescents are involved in leisure therapy activities. The leisure therapist assesses age appropriate functioning and development of leisure skills. Leisure activities are utilised as a tool by which to develop life skills and manage the symptoms of mental illness.

Members of the staff may be contacted by calling our reception on **3271 8742**. If you would like to attend an interview with any member of the Treatment Team, it is best to ask your adolescent's Case Coordinator to arrange this.

Of course you may also phone your adolescent while they are at the Centre. Due to the school and activities program conducted at the Centre, the best times to phone are from 7pm until 9pm Monday to Thursday, after 3pm on Friday and any time from 10am until 9pm on weekends. The phone number to call is **3271 8762**.

If you wish to discuss issues relating to academic performance, your adolescent's teacher is available and can be contacted on **3271 8739**.

Most families have the opportunity to attend family meetings. This will involve attendance by the family at regular sessions with the family therapist.

Our Clinical Liaison Person also organises a Parents Support Group, which meets one evening during the week on a monthly basis. This is a valuable opportunity to share your own experience with other parents who face similar issues. It is also an opportunity to meet with staff and discuss issues relating to the Centre.

Attachment 6

CIMHA (Consumer Integrated Mental Health Application) is a consumer-centric clinical information system designed to support mental health clinicians in the provision of safer quality mental health services. CIMHA supports mental health service delivery by providing timely access to up-to-date clinical information across service settings and between Hospital and Health Services in Queensland.

CIMHA users are able to review consumer demographic and clinical information, activity, Mental Health Act 2000 and outcomes in one location and use this to inform treatment plans, evaluate service delivery and assist with service planning.

Consumer information must be entered in CIMHA to comply with the mental health Models of Service, State-wide Policies, and a requirement to keep full and accurate records under the Public Records Act 2002. To support service provider communication and consumer continuity of care, to enable analysis of the impact of clinical activity on consumer outcomes, to support local and state service planning and prioritisation and to support State and the Commonwealth reporting.

All consumer Referral details including, referral status, presenting problems, internal contacts and treating unit information, all Service Episodes including start and end details, internal contacts and treating unit, diagnosis, outcomes and clinical notes (scanned or direct entry) should be recorded/entered into CIMHA. Any data warnings and data discrepancies, demographic details including the current living address and phone numbers, external contacts including the preferred contact, allied person and general practitioner details, alerts, internal contacts, recovery plans / care plans / treatment plans and the Involuntary Patient Summary (IPS) and photo where required should also be recorded and updated in CIMHA.

CIMHA has a Consumer Care and Review Summary clinical note template with the ability to scan and upload external PDF documents. CIMHA has the function to plan, record and report on Consumer Case Review dates via the Provision of Service (POS) module in-line with the National Mental Health Standards.

CIMHA has an End of Discharge Summary clinical note template with the ability to scan and uploaded external PDF documents. This should be completed as per the state Key Performance Indicator and in-line with the Standardised Suite of Clinical Documentation (Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch).

CIMHA is on the Orientation Program and all clinical staff are required to attend the training prior to having access.

Attachment 7

Queensland Health

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Procedure

Document ID DDWMProc201000447

Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts
Division of Mental Health
Darling Downs – West Moreton Health Service District

Custodian/Review Officer:
Executive Director Mental Health

Version No:

Applicable To:
Division of Mental Health Staff

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Executive Director Mental Health

Approving Officer:
Shirley Wigan
Executive Director Mental Health

Signature:

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Key Words: mental health, transfer, interdistrict, facility

Accreditation References:
National Mental Health Standards: EQuIP criteria and standards

EQuIP 5 – 1.1, 6.4, 10
NSMHS 2010 – 6.1, 6.3, 10.5, 9

1 Purpose

This procedure describes the processes for by which mental health consumers of South Queensland Health Service Districts receive an efficient, consumer focused transition of care between mental health services.

2 Scope

It is well established that mental health consumers are at an increased risk of harm during periods of transition. *South Queensland Health Service Districts* are committed to an agreed procedure to ensure the comprehensive management of consumer transition between mental health services. This procedure clarifies and standardises the roles, expectations and responsibilities of transferring and receiving services in the management of mental health consumer transitions between services.

PRINCIPLES

During the transfer of care of mental health consumers between services:

- The cultural needs of the consumer and their carers will be acknowledged and respected (See APPENDIX A).
- Mental health services will work collaboratively to ensure a consumer focused transition of care.
- The transfer process, including the time it takes to complete, will be consistent with consumers' recovery / care / treatment plans e.g. efforts made to support the consumer's ongoing access to their care network if they are from a rural and remote area and are transferred out of area.
- Some transfers of consumer care may require a shared care arrangement for a period of time.
- If a clinical difference of opinion occurs regarding the ongoing management of a consumer transferring between districts, the consultant of the receiving service has the final decision and responsibility for the ongoing care.
- Allowances may be made for consumers who are mental health service employees.

3 Procedure:

Note regarding the transfer of clinical information:

The steps required to transfer consumers between services will vary dependent upon the service type the consumer is transferring from and to. For transfers of consumers between all service types, the following (most recent) information is required (when it exists):

- Consumer demographic information form (demographic information generated from CIMHA is also acceptable)
- Consumer intake form
- Consumer assessment form with associated assessment modules attached (for initial assessments: particularly the Family Developmental History and Social Assessment)
- Recovery Plan (Note: the recovery plan has 3 sections: 1) recovery plan – consumer focused; 2) individual care / treatment plan – service / duty of care focused; 3) relapse prevention plan).
  An *individual care / treatment plan* generated from the care planning module in CIMHA is also acceptable.
- Consumer End of Episode/ Discharge Summary

Clinical documentation should be recorded on the Queensland Health Mental Health standardised suites of clinical documentation forms. Notes written by non MH staff (e.g. ED clinicians) may be recorded in other formats.

In the event that these forms have never been completed by the transferring service, the Consumer End of Episode/Discharge Summary is mandatory from inpatient service providers, the intake / assessment information is mandatory from ACT / ED services and the Consumer End of Episode / Discharge summary is a minimum requirement from Community Service Providers (including MIT services). These forms therefore must be completed by the transferring service prior to transfer unless exceptional circumstances exist (e.g. emergency transfer from rural ED where no after hours mental health staff to complete standard suite of documents)
Documentation in these circumstances must include:

- Risk Screen (if not recorded on intake or assessment form)
- Medical Officer R/V notes if initial MH assessment has not been completed
- MHA 2000 documentation (if applicable)
- Medical Assessment & Clearance

When possible, the transferring service should forward clinical documentation to the receiving service at least 3 days prior to the transfer of clinical care of the consumer.

Clinical information may be transferred via email or facsimile. The transferring service must ensure the information has been received by the receiving service and must document in the consumer's medical record that this has occurred.

Note regarding mandatory steps for any transfer of consumer care:

- The receiving service contact details and follow up appointment details must be noted in the consumer's transferring service medical record prior to transfer.
- Unless a consumer does not grant permission for mental health service providers to contact their carers and / or families, prior to the transfer of a consumer's care, the transferring service Principal Service Provider (PSP) or equivalent, must notify (at

the minimum) and preferably consult with the consumer's carers and family regarding the pending transfer of care.

1. Transfer of Community Voluntary Mental Health Consumers

1.1 Consumers choosing not to engage with the Community MHS within their destination District

1.1.1 The transferring service will contact the receiving service to advise of: the consumer's relocation to the receiving district; and, the CIMHA reference number (when available), for information only.

1.1.2 The transferring service will document contact with receiving service in the consumer's medical record prior to case closure.

1.2 Consumers choosing to engage with private sector support services in their destination District

1.2.1 With consumer consent the clinical information above will be provided to relevant mental health service provider/s e.g. GPs, private psychiatrists, NGO's. The transferring service will document contact with the follow up care providers in the consumer's medical record prior to case closure.

1.2.2 The Principal Service Provider (PSP) from the transferring service will contact the consumer, following their relocation, to confirm and document that they have engaged with clinical / support services in their destination district.

1.2.3 If the consumer has not engaged with clinical / support services as planned, the transferring service PSP will determine if further action is required. If the consumer requires follow up from Queensland Health Services, refer to procedure 1.2 for voluntary consumers and 2.0 for involuntary consumers.

1.3 Consumers choosing to engage with the Community MHS in their destination District

1.3.1 The transferring service will contact the receiving service via their intake officer/team leader (rural services), and will forward the information noted above (Page 2).

1.3.2 The receiving service intake officer/team leader (rural services) will facilitate the intake process to determine the follow up care which will provided in accordance with local processes (including dissemination of clinical handover information).

1.3.3 For cases where the consumer is accepted for follow up into a community team (including ACT and MITT) the receiving service follow up team will facilitate principal service provider (PSP) face to face contact with the consumer as soon as is required as determined by clinical need, but no later than 14 days. If any consumer has to wait for face to face contact with the receiving service for longer than is clinically acceptable, the transferring service will continue to provide care during the transition period (for up to 14 days, as negotiated between the transferring and receiving services). If it is geographically impractical for the transferring service to provide face to face transition care once the consumer moves into their destination district, the transferring service will maintain telephone or video link transition care as an alternative until the consumer attends their first appointment with the receiving service.

Note: When a consumer is transferred between services following an inpatient episode of care, face to face contact is mandatory within 7 days of discharge from the inpatient unit.

2. Transfer of care for involuntary mental health consumers

2.1 Transfer of care of involuntary consumers under the MHA2000, who are not forensic consumers

2.1.2 The procedure for transfer of care of involuntary consumers under the MHA2000, who are not forensic consumers, is the same as for voluntary consumers above, with the exceptions that:

- The appropriate MHA2000 documentation must be transferred. This includes the treatment plan (all consumers) and making contact with the receiving districts MH Act Coordinator to advise of transfer and legal status.
- The consumer's forensic history must be forwarded by the transferring service with the other clinical information required.
- In the event that the transferring service is providing transition care for up to 14 days, if the consumer breaches the conditions of their treatment plan (e.g. is non compliant with medication), the transferring service will manage this clinical issue during the transition period. If the transferring service requires access to local networks (e.g. emergency services) they may make contact with the receiving service for this information.

2.2 Transfer of an involuntary consumer from an inpatient service to a community service

2.2.1 For inter-district transfer of an involuntary consumer from an inpatient service to a community service, the following requirements also apply:

- Consultant to consultant liaison/team leader (rural services) contact is required prior to discharge from the transferring service.
- If a case manager in the receiving service is not allocated at the time of transfer, the interim PSP is the team leader of the receiving service community team.
- The Nurse Unit Manager of the transferring service is responsible for liaising with the case manager/ team leader of the rural team prior to the consumer transfer, for rural discharges.

2.3 Mental Health Act Administrator (MHAA)

- When receiving notification of a transfer of an ITO via CIMHA email facility, the receiving service MHAA will confer with the Team Leader of the relevant team to establish if the transfer process has been completed and the consumer has been accepted to the service.
- When the referral has been accepted the receiving service PSP (usually a case manager) will notify the transferring service team and the receiving service MHAA so transfer of the ITO can be arranged.
- If the transfer is not complete, the receiving service MHAA must inform the transferring service that the ITO is to remain with them until the process is completed.
- If the consumer has been accepted to the receiving service, the ITO must be accepted by the receiving service MHAA.

3. Transfer of care for forensic mental health consumers

3.1 Procedure for forensic consumer under the MHA2000

3.1.1 The procedure for transfer of care of forensic consumers under the MHA2000 is the same as for involuntary consumers above, with the exceptions that:

- The District Forensic Liaison Officers (DFLO) from the transferring and receiving services will be in contact with one another throughout the transfer process.
- The DFLO from the transferring service will facilitate the transfer from the transferring service end (and therefore will be the person who will be making contact with the receiving service).
- The DFLO from the transferring service may continue to share care / liaise with the receiving service DFLO regarding the consumer's care for up to 3 months (as negotiated between the transferring and receiving services dependent upon clinical need). It may be necessary to negotiate a shared care transition plan which includes risk management. The transition plan will provide guidelines to manage issues of non compliance and indicate who is responsible for managing the consumer should a psychiatric emergency arise. The intention of the transition plan is to ensure: consistency and continuity of care; and that the consumer is suitably monitored and is unable to avoid follow up as a result of not attending appointments, or being absent without leave or frequently moving address. The duration of the transition plan should be for a maximum period of three months and should be ended as soon as the receiving service is clinically confident that they have sufficient understanding of the consumer to no longer require transferring service support.
- The State-wide Director of Mental Health (DOMH) must authorise (via written authorisation) the transfer of forensic consumers from one Authorised Mental Health Service (AMHS) to another AMHS. The transferring AMHS will commence completion of the *Request for Transfer – classified/forensic/court order patient* form (an authorised Doctor only can complete some sections of this form). This form is then provided to the new AMHS for their completion. On final completion, the form is faxed to the DOMH.
- The DOMH must be satisfied that appropriate follow-up arrangements are in place for the consumer and that the transfer has been accepted by the Clinical Director/Administrator (or equivalent in rural areas) of the receiving service. This includes allocation of an authorised psychiatrist to the consumer prior to the transfer of the order.
- Until the DOMH transfers the order to the new AMHS the transferring AMHS remains responsible for the consumer's treatment as prescribed in the treatment plan, including taking appropriate actions when the consumer is non-compliant with the treatment plan. This will occur with assistance from the receiving service to access local networks if required in geographically isolated areas.
- Additional information which must be forwarded by the transferring service to the receiving service for transfer of forensic consumers includes: last MHRT report – attached treatment plan and LCT provisions; and, summary of forensic issues/outstanding matters (Summary page – Query IPS – CIMHA).
- The receiving service may request extra documentation from the transferring service to assist with development of follow up care plans. This may include:
- Medico legal Reports (238 Report, current LCT plan and conditions).
- Crisis Management Plan.
- Relevant Clinical Reports (e.g. Forensic Order Report, CFOS assessment).
- Recent progress notes.

3.2 Transfer of care for 'Special Notification of Forensic Patients" (SNFP) mental health consumers

3.2.1 The procedure for transfer of care of SNFP consumers under the MHA2000 is the same as for forensic consumers above, with the exceptions that:
- The Clinical Director (or equivalent) of the transferring service will contact the Clinical Director (or equivalent) of the receiving service to inform them of and discuss the pending transfer.

3.3 Transfer of care for Involuntary/Forensic consumers on short term travel

Note: The MHA2000 Resource Guide, Chapter 8 "moving and transfer" does not specifically address the issue of holiday or interim care delivery for persons under the MHA2000 who are holidaying within Queensland away form their treating district. Interstate travel is addressed. Consideration of the consumers' rights must be made when determining appropriate management of this issue.

Key issues to address will include but are not limited to:
- Length of planned holiday period
- Distance between holiday and home district
- Conditions of leave
- Medication prescription and administration
- Treatment required
- Social supports required

According to *Forensic Patient Management Policy and Procedures*, (Queensland Forensic Mental Health Service), in addition to permanent transfer, Forensic Order movements may be: short term (a couple of nights, for example a holiday); and, regular short terms (for example, visiting relatives in another District). Regardless of the time length for Forensic Order movement, the following minimum level of information should be provided to the receiving DFLO and District:
- Request for transfer: Classified/Forensic/Court order patient.
- Written Authorisation from Director of Mental Health (DMH).
- Standardised suite of forms – Consumer Demographics, Copy of Consumer Intake, Consumer Assessment, and Drug Assessment.
- Summary Page – Query IPS (CIMHA).

4. Transfer of Consumers to a MHS Inpatient Unit

4.1 Consumers presenting to the Emergency Department who require inpatient admission and reside in another District

4.1.1 Consumers should be treated as close to their home as practicable, to minimise disruption to social networks and functioning.

4.1.2 All consumers presenting to the Emergency Department will be assessed regardless of their district of origin.

4.1.3 Following the decision that admission is required, the assessing district will contact the consumer's district of origin and notify them of the consumer's presentation and their status.

4.1.4 Pending bed availability and not withstanding any other agreement between districts, the consumer's district of origin will receive the referral and accept the consumer within a two hour period (between 0800 hrs and 2300hrs). Transport arrangements are the responsibility of the transferring district. Ideally, within the SQHSD

metropolitan area, districts will facilitate the acceptance of transfers from 0800hrs to 2000hrs. These transfers should be planned to be completed prior to 2300hrs.

4.1.5 If there is no bed available at the consumer's district of origin or a safe transfer is not possible at the time, the consumer should be admitted to an appropriate ward and treatment commenced until such time as a bed in the consumer's district of origin becomes available.

The transfer of clinical documentation is to be recorded in the consumer's medical record as noted above (Page 2).

4.2 Consumers presenting to a rural service Emergency Department who require inpatient admission

Note: In 2009, all rural services in South Queensland are part of a District with inpatient beds. However, the service with the inpatient beds may be some distance from the rural service needing to admit a consumer. In the first instance, a rural service should always try and admit consumers to their own district (this is an intra rather than inter district transfer). In circumstances where a rural service is unable to admit consumers to a bed in their own district, a bed in another District receiving service will need to be found and the following applies:

4.2.1 Following the decision that admission is required, the assessing district will contact the receiving district, through the receiving Acute Care Team and notify them of the consumer's presentation, their status and need for admission. The receiving service will make contact with the relevant psychiatrist to confirm and support admission to the inpatient unit. All relevant paperwork related to an involuntary admission (e.g. recommendation and request for an assessment forms and request for police escort) with be completed by the on site medical officer and mental health worker (during business hours).

4.2.2 Pending bed availability, the receiving district will receive the required material for admission and accept the consumer within a two hour period (between 0800hrs and 2300hrs). Transport arrangements are the responsibility of the transferring district. Within rural areas transfers should ideally occur during business hours. The above hours are to be seen as flexible and able to be negotiated between services taking into account the needs of the consumer, the availability of human resources and the ability of the transferring service to maintain the safety of the consumer and staff in the facility prior to transfer.

If for any reason, the rural transferring service is not able to affect the transfer immediately, the "home" mental health service should put in place strategies to assist in maintaining the consumer safely until the transfer can occur. These strategies would include but not be limited to:-

- Access to a Psychiatric Registrar or Consultant for advice and support
- Video-link assessment or review if required
- Advice and support about the most appropriate transfer mode

4.2.3 If there is no bed available at the receiving district or at other suitable facilities (relevant to CYMHS consumers only) or a safe transfer is not possible at the time and the transferring facility has the capacity to ensure the safety of the consumer and staff, the consumer should be admitted to an appropriate hospital ward and treatment commenced, with consultation from the "home" inpatient psychiatrist until such time as a bed in the receiving inpatient unit becomes available.

4.3 Consumers who present or are presented to an Emergency Department and are on an Authority to Return to another District

4.3.1 Consumers that are brought to the Emergency Department on an Authority to Return from another Authorised Mental Health Service are to be assessed upon their presentation.

4.3.2 It is expected that the service who has issued the Authority to Return document will make available all information to facilitate this assessment.

4.3.3 If, following assessment the consumer requires admission, refer to section 4.1.

4.4 Temporary transferring of inpatient care to another District during bed shortage

4.4.1 MHSs within the SQHSD have agreed to provide for the temporary care of consumers from other districts when these districts are experiencing bed shortages. Prior to this occurring, the local MHS should make every attempt to manage the consumers in their local district. Other options to be considered are:

- Assertive community treatment
- 'Outlying' appropriate consumers to a medical bed with specialist mental health support in order to make an acute MH bed available
- Overnight management of the consumer in the Emergency Department, with specialist mental health support.

4.4.2 The following process is to occur to facilitate all inter-district transfers due to local bed availability shortages:

- The delegated MHS Bed Manager from the transferring district will make contact with each delegated MHS Bed Manager within SQHSD to assess availability of beds.
- Pending bed availability the receiving district will receive the referral and accept the person within a two hour period.
- Documentation to accompany the transfer is as above (section 4.1.5).

4.4.3 Inter-district transfers due to bed availability should occur within business hours whenever possible. Transfers outside of business hours are at the discretion of the Consultant on call and must take in to account the availability of medical and nursing staff to safely facilitate the transfer in both transferring and receiving services.

4.4.4 It is preferable that a consumer requiring inpatient care within a High Dependency area NOT be transferred to another district, due to the:

- Acute nature of their mental state.
- Likelihood of requiring high doses of medication which may compromise their physical health status.
- Identified benefit of having ready access to their usual treating team.

4.4.5 The return of persons that have been transferred to another district is to be negotiated between the transferring and receiving services. Factors to be considered should include the consumer's clinical needs, the consumer's choice and the consumer's discharge address. The number of transfers for each consumer should be minimised as much as possible.

4 Supporting Documents

- See References

5 Definition of terms

Term	Definition	Source	See also
Queensland Private Health Care Sector:	Health Care services which are not Queensland Health provided:	South Queensland Health Service Districts	Nil
SQHSD:	South Queensland Health Service Districts.	South Queensland Health Service Districts	Nil
DOMH:	Director of Mental Health	South Queensland Health Service Districts	Nil
MHS	Mental Health Service	South Queensland Health Service Districts	Nil
SNFP	Special Notification Forensic Persons	South Queensland Health Service Districts	Nil
MHA:	Mental Health Act 2000	South Queensland Health Service Districts	Nil
CIMHA	Consumer Integrated Mental Health Application	South Queensland Health Service Districts	Nil

5 References and Suggested Reading:

The MHA 2000

The MHA 2000 Resource Guide

National Safety Priorities in Mental Health: A National Plan for Reducing Harm

National Standards for Mental Health Services 1996

Queensland's Mental Health Patient Safety Plan 2008 – 2013

Queensland Plan for Mental Health 2007 – 2017

Queensland Health Mental Health Standardised Suites of Clinical Documentation User Guides (2008, 2009)

6 Consultation

Key stakeholders (position and business area) who reviewed this version are:

Southern Qld Health Service Districts Mental Health Network – Working Party and consultation with district based staff.

7 Procedure Revision and Approval History

Version No	Modified by	Amendments authorised by	Approved by

8 Audit Strategy

Level of risk	
Audit strategy	Ongoing review by Southern Qld Health Service Districts Mental Health Network
Audit tool attached	Nil
Audit date	12 months from endorsement
Audit responsibility	Division of Mental Health Clinical Governance
Key Elements / Indicators / Outcomes	Improvement to patient care upon transfer

9 Appendices

APPENDIX A

Cultural considerations when transferring consumers

Cultural factors of consumer transfer between districts include the cultural sensitivity of the transfer/relocation of a consumer. Mental health staff in both the transferring and receiving services must obtain access to cultural expertise and advice.

Factors to be aware of:

- Locality/community

- Transferring service to liaise with Indigenous and culturally and linguistically diverse (CALD) mental health workers
  - Within their team and with the receiving district
- Social and emotional well being considerations
  - links to family, friends, elders

Locality/community – when Aboriginal and Torres Strait Islander people are local to a specific area/town/city/suburb cultural protocol states the mental health service will contact the local Aboriginal or Torres Strait Islander community. There are several ways of contacting and involving the Aboriginal and Torres Strait Islander community:

- Through family connection if the consumer has a relative within that particular community
- Consulting the Indigenous mental health worker in the receiving district.

If the consumer is going to a community that is not well known the Indigenous mental health worker must provide orientation for the consumer to the local Aboriginal and Torres Strait Islander community, with the consumer's consent.

Transferring service – It is the responsibility of the clinical team/case manager to notify the Indigenous mental health worker in the receiving district of the transfer of the consumer, whether to private or public follow up care. In the event that there is no mental health service in a community, notification to the Aboriginal Medical Service in that community is recommended. The Indigenous mental health worker from the transferring service needs to be involved / consulted in the transfer of all Indigenous consumers of mental health services.

In addition, the consumer's family, allied person, etc need to be notified of the transfer between districts, with the consumer's permission. Sometimes family exist in both the transferring district and the receiving district.
Consumers need to be orientated to the new district for services and links with Aboriginal and Torres Strait Islander organisations, such as the Aboriginal Medical services; cultural events, activities and meetings; other Queensland Health services and other Queensland Government services.

Social and emotional wellbeing - Following on from this, the consumer's social and emotional needs in the receiving service has to include: family and other relationships; cultural connections/support; other health concerns; housing; income; spirituality; stability of home environment; and, culturally appropriate psycho social interventions in the areas of: further education; diversional activities; fitness activities; clubs etc.

Attachment 8