Eastern Mental Health Service Coordination Alliance

"Creating opportunities to work strategically across the region with Multi- Sectoral partners"

EMHSCA Collaborative Pathways Subcommittee

Shared Care Practices and Collaborative Planning Protocol

Implementation Strategy

State Government Victoria Department of Health

Eastern Mental Health Service Coordination Alliance

Developed by the Eastern Mental Health Service Coordination Alliance (EMHSCA)

Background

The Eastern Mental Health Service Coordination Alliance (EMHSCA) Collaborative Pathways Subcommittee was formed in December 2012.

The purpose of the Subcommittee is to explore how member agencies can work together to improve the holistic health outcome for people with mental health and co-occurring concerns by supporting the development and implementation of shared protocols and documentation within and between member agencies.

Vision

“All participating agencies offer opportunities for people to participate in a person centered, integrated, shared care plan with a recovery focus.”

The Collaborative Pathways Subcommittee (CP SC) has reviewed the previous Shared Care Protocol and Individual Recovery Plan in collaboration with EMHSCA and the Dual Diagnosis Consumer and Carer Advisory Council (DD CCAC).

The members of EMHSCA agreed in principle to the revisions that are now provided in the Shared Care Practices and Collaborative Planning protocol (SCP&CPP) at their November 2013 meeting.

The CP SC was supported by EMHSCA to develop this implementation strategy for consideration of its member organisations.

Objective

To raise awareness, amongst EMHSCA member services and others, of the existence and content of the SCP & CP Protocol

To support agencies as they align their practice with the SCP & CPP

To support agencies in the introduction of appropriate shared care documents

Suggested strategies for implementation

1. ☐ Embed SCP & CPP as part of your current model of service provision

Ensure the key elements of the SCP & CPP are highlighted and addressed as part of your service's response to implementing models of service provision such as the new Mental Health Act, Recovery framework etc…

2. ☐ Add the SCP & CPP to Orientation for new staff

Ensure all new staff are aware of the SCP&CPP document as they enter your workforce. This may be done by registering them to attend the next Collaborative care planning workshop and/or by providing the document for them to read at Orientation.

Organizations may also want to consider inviting new staff from other organisations within the sector to specific teams in the region to learn about what services the other provides, similar to that of a reciprocal rotation. This networking would support staff to develop relationships with other workers and increase their knowledge of the service system which will better aid them in supporting client needs.

3. ☐ Work together with the Workforce Development Committee to build capacity of organisations by

a. Ensuring your organisation has an EMHSCA Workforce Development Committee (WDC) member
b. Send staff to EMHSCA WDC events
c. Provide feedback to EMHSCA WDC following events

4. ☐ Embed elements of example policy into existing service policy frameworks (see appendix A)

Examine current policy in relation to Service Coordination elements

5. ☐ Embed key elements described in protocol into job descriptions (see Appendix B)

Examine current job description statements and consider appropriate Service Coordination criteria be added if found to be absent.

6. ☐ Examine current care planning tools to ensure SCP & CP Protocol recommendations are taken into account

Each agency will examine its current care planning tools and practice to ensure that:

- ☐ Written consent is gained from the consumer before any shared care planning
- ☐ The core components of the shared care plan as per page 4 of the SCP & CPP are included in your services' Care planning procedures i.e. Individual recovery plan, wellness plan and safety assessment and management plan
- ☐ Reviews occur at least 3 monthly, involving all parties concerned

7. ☐ Incorporate Shared Care planning and collaboration as standard item at team meetings –

Team meetings to incorporate promotion of collaborative practice including awareness/education of other service providers, presentations from other services, promoting clear and regular communication between providers, and promoting shared care planning/problem solving.

8. ☐ Include shared care conversations in clinical reviews, appraisals and supervision or similar forum. –

Individual supervision, direct line, practitioner focused, opportunity to examine practice in relation to complex cases. The usual focus of discussion is around risk and the collaborative work involving external services involved in the shared care of the client.

Group Supervision provides opportunity for collective feedback around appropriate referral pathways between agencies, and building capacity to provide holistic and coordinated responses.

Complex Case Panel, a multidisciplinary panel, who provide recommendations to ensure an integrated approach for relevant internal and external services for the most high risk cases identified by the organization.

Internal Case Allocation Meetings identify the potential for both internal and external services to offer a wrap around treatment plan for individuals and families within six weeks.

9. ☐ Participate in EMHSCA Shared care auditing in conjunction with the CP SC

An annual audit of Shared Care Practices in the EMR will be conducted by the EMHSCA, first conducted February 2014, with the aim of monitoring improvement in shared care practices in this region.

File audit questions regarding shared care practice could be included in an organisational file audit process. An example of a set of shared care file audit question criteria has been included in **Appendix H.** These questions are linked to the shared care practice performance indicators documented in Appendix B, these being:

- Shared care practice occurs when the consumer is identified as requiring a coordinated response from multiple services.
- Shared care planning occurs within and across organisations for consumers needing shared care support.

- A shared care plan document is used to facilitate communication with the health team, consumers, families and carers.
- The consumer, carer and advocate are supported to actively participate in the shared care planning process.

10. ☐ Appoint Service Coordination Champions to lead staff change (see appendix C)

Identify front line staff that have a particular interest in collaboration with other agencies, consumers and carers. Support them to meet with Mental Health Service Coordination leaders and attend monthly Linkage meetings as scheduled. Encourage them to provide service coordination information to their teams.

Service Coordination Champions may also be Dual Diagnosis champions/portfolio holders, AOD Care and Recovery coordinators etc…

APPENDICES

Appendix A Policy Example

Appendix B Job Descriptions

Appendix C Service Coordination Champion Role

Appendix D Shared Care Practices and Collaborative Planning Protocol

Appendix E Individual Recovery Plan example

Appendix F Wellness Tool example

Appendix G Safety Assessment and Management Plan example

Appendix H Audit questions

Appendix A

Policy example

EMHSCA CP SC is committed to facilitating the delivery of quality integrated & coordinated services which will work effectively for better care. We will develop relationships with clients, and as appropriate, their carers, family members, significant others and other professionals that build positive partnerships and support enhanced perspectives. We acknowledge the importance of sharing client information between agencies, with client consent, in order to provide a person-centred response to individual needs and the delivery of a coordinated approach.

Note: This example was developed by examining a number of existing policy statements. It may be used as it is or developed with the key elements in tact.

Appendix B

Job Description statement

Key Selection Criteria

Entry level:

- Ability to liaise, collaborate and negotiate with other services and consumer and carer groups

More experienced staff:

- Demonstrated experience to liaise, collaborate and negotiate with other services and consumer and carer groups

Leadership Level:

- Demonstrated high level ability to liaise, collaborate and negotiate with other services and consumer and carer groups

Major Responsibilities

Organisational /Leadership level:

There are supportive structures in place to enable staff members to:

- collaborate, liaise and negotiate with other services for mutual clients requiring a coordinated service response

- Initiate and develop shared care plans in partnership with consumers, families, carers and other health professionals.

Practice/ Service provider level:

There is demonstrated evidence that:

- Shared care practice occurs when the consumer is identified as requiring a coordinated response from multiple services.

- Shared care planning occurs within and across organisations for consumers needing shared care support.

- A shared care plan document is used to facilitate communication with the health team, consumers, families and carers.

- The consumer, carer and advocate are supported to actively participate in the Shared Care Planning process.

Note: This provides an example only and needs to be translated into local service context.

Appendix C

Service Coordination Champion Description

Service Coordination Champions will lead their service, its staff and its consumers and families to maximize opportunities for accessing the services required to facilitate the individual's recovery journey. They will do this by

a) Liaising with management/team leaders around the principals outlined in the Victorian Service Coordination Practice Manual and the Shared Care Practices and Collaborative Planning Protocol.

b) Holding responsibility within their service for disseminating Service Coordination and Shared Care Practice related information to the rest of their team,

c) Supporting the EMHSCA Workforce development committee member in advertising Collaborative and Recovery focused workshops and encouraging staff attendance,

d) Offering support to their fellow staff around Collaborative Care planning issues and/or negotiating contact with a Care Coordinator/Support facilitator when required,

e) Attending professional development opportunities re Service Coordination when able,

f) Obtaining or organising for the purchase (by their service) of relevant resources to enhance understanding of Service Coordination.

g) Attending Dual Diagnosis **Linkages meetings** and reporting back to team members.
Dual Diagnosis Linkage meetings provide an opportunity for Service Coordination Champions to network, gather service information, discuss shared care cases and learn about service innovations.

h) Attending Service Coordination Champion gatherings.
Service coordination gatherings will be arranged to bring Champions together and discuss the role, progress, resources etc…
They will be held up to, and no more than, 4 times per year.

i) Facilitating **reciprocal service orientations** (optional) (see description)

Reciprocal Service Orientation (RSO) –

Service Coordination Champions may be called upon by their organisation or by external professionals to facilitate the introduction of professionals to their organisation and / or service areas; with a view to promoting collaborative and purposeful professional relationships aimed to enhance better treatment outcomes for consumers their families and communities

Leadership for Service Coordination Champion Role

A member of each EMHSCA organisation will be nominated to provide leadership to their local Service Coordination Champions. These leaders will form the membership of the Collaborative Pathways subcommittee of EMHSCA for as long as this committee is in operation. In the event of this committee disbanding an alternative network for the Service Coordination Champion leadership will need to be identified.

References

AOD Service Coordination Toolkit 2012 http://www.easternhealth.org.au/app_cmslib/media/umlib/mental%20health/emhca/eastern%20metropolitan%20region%20alcohol%20and%20other%20drug%20sector.pdf

Victorian Service Coordination Practice Manual 2009 http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf

Victorian strategic directions for co-occurring mental health and substance use conditions 2013 http://docs.health.vic.gov.au/docs/doc/Victorian-Dual-Diagnosis-Initiative-(VDDI)-Bulletin--October-2013

Framework for Recovery-Orientated Practice 2011 http://www.health.gov.au/internet/main/publishing.nsf/Content/0ABBFD239D790377CA257BF0001C6CBC/$File/colsev.pdf

Twelve Steps for Agencies developing co-occurring disorder capability https://www.idph.state.ia.us/bh/common/pdf/substance_abuse/integrated_services/12_steps_programs.pdf Evaluation of Stronger Families and Communities Strategy 200-2004 – Improved Integration and Coordination of Services - RMIT 2008

Mental Health Coordinating Council 2012, Service Coordination Workforce Competencies: An investigation into service user and provider perspective, MHCC, Sydney. http://mhcc.org.au/media/3200/service-coordination-workforce-competencies.pdf

Eastern Mental Health Service Coordination Alliance

Appendix D Shared Care Practices and Collaborative Planning Protocol

OVERVIEW

The aim of establishing and maintaining shared care arrangements for mutual consumers is to facilitate the recovery process and assist consumers to regain their place as involved members of the community. This will be supported by the provision of collaborative and coordinated service delivery by partner agencies.

When an individual is identified as requiring the assistance of multiple services within the Eastern Mental Health Service Coordination Alliance (EMHSCA), service providers should come together with the consumer to:

- Establish agreed working practices with the shared consumer and secondly to
- Consider the development of a shared care plan.

The shared care plan will promote a shared understanding of the consumer and their personal recovery goals promote consistency in practice and ensure all parties are working towards the consumer's identified goals.

With the consent of the consumer, family members or others involved in a care giving role should be encouraged to be involved in shared care arrangements as well as the development of a shared care plan (where appropriate). The consumer should have his/her own copy of the plan/s, and where indicated copies should be provided to all parties involved in the plan.

Consent, confidentiality, and appropriate information sharing are central tenets to recovery oriented shared care and as such there are a number of links provided on page 5 to assist service providers.

PROTOCOL OBJECTIVE

The aim of this guideline is to ensure optimum responsiveness and support for the needs of consumers and their families/carers involved with several services in the Eastern Mental Health Service Coordination Alliance. These guidelines also provide a useful benchmark for Alliance members' interactions with other services not part of the Alliance, but with whom there are shared consumers.

The scope of the guidelines includes:

1. Collaborative practices for service providers when working together with shared consumers
2. Collaborative practices for the development of shared care plans

DEFINITIONS

- **Eastern Mental Health Service Coordination Alliance Services (EMHSCA)** – All Eastern Metropolitan Region of Melbourne services involved in the provision of care to people with a mental health concern who have signed the EMHSCA Memorandum of Understanding 2013.

- **IRP** – Individual Recovery Plan

- **Consumer** - a person, who has been diagnosed with a mental illness, has direct experience of Mental Health Services or identifies as a consumer [VMIAC's definition].
  - The term "consumer" refers to people, who directly or indirectly make use of mental health services.

- **Carer** - the family members and friends of someone with a mental illness whose lives are also affected by the mental illness. Many people fall into the role of 'Carer' because they see it as an extension of their responsibilities within the relationship they have with the person with mental health issues (Information for Families and Carers of People with Mental Illness DHS 2005)- Carers can provide from a few hours care per week up to 24 hours a day. Carers may not necessarily live with the person for whom they care.

- **Planning Coordinator** – The person identified by the consumer (or otherwise by consensus) as the most appropriate to coordinate the care planning process and the contributions of all involved parties. This role involves arranging meetings with all parties to the consumer's plan and facilitating the updating and circulation of the consumer's plan. Note: A Support Facilitator or Care Coordinator could take on this role where appropriate.
- **Care Coordinator/Support Facilitator** – Person specifically employed to support and coordinate the provision of timely and appropriate care to people with multiple and complex needs.

- **Clinical Case Manager/clinician** – an employee of the Adult Mental Health Program providing direct clinical service.
- **Community Mental Health Practitioner** - an employee of a Mental Health Community Support service providing direct support.
- **AOD Practitioner** - an employee of AOD agency providing AOD service in partnership with the client to complete an episode(s) of care with client directed treatment goal(s).
- **Support Worker** – an employee of the Homelessness or other support service providing direct support during an identified time frame.
- **Clinical Services –** When the term 'Clinical Services' is used in this document – it is referring to *Clinical Mental Health Services only.*

- **OCP** – Office of the Chief Psychiatrist
- **MH** – Mental Health
- **AOD** – Alcohol and Other Drugs

SHARED PRINCIPLES OF OPERATION

Organisations and their staff will:

- Ensure the assessment of each consumer's recovery and support needs and development of personal goals are undertaken collaboratively by consumers and their service provider.
- Work in partnership with the client and other organisations when an interdisciplinary approach is needed, thus forming a **Shared care team**.
- Ensure that the consumer is at the centre of the process.
- Work together to coordinate provision of the right service, at the right time and right place.
- Assist consumers in a seamless and timely manner, by streamlining access to appropriate services through self referral or assisted referral.
- Provide timely, relevant and appropriate access to information to enable informed decision making.
- Respect a consumer's right to privacy.
- Facilitate individual choice and understanding.
- Proactively embrace change and new opportunities.
- Work toward good practice as outlined in the Victorian Service Coordination Practice guidelines (see link on Pg 5)

SHARING OF INFORMATION

Effective cross service communication

All staff are expected to maintain communication around:

- Entry into and exit from services (including any inpatient admissions)
- Assessment outcomes and risk assessment
- IRP development and review, including planned interventions
- Significant changes in the consumer's level of needs
- Triggers, stressors and/or significant changes in mental state or associated behaviour
- Medication and/or treatment changes that may have an effect on support needs
- Significant changes to appointment frequency or non-attendance at scheduled appointments
- Critical incidents
- Referral to alternative services
- Change of worker or treating team

Each agency is responsible to ensure they keep all members of the Shared care team informed of any changes in the consumer's situation.

(For further information refer to Chief Psychiatrist's Guideline 2010: *Information sharing between AMHS and PDRSS*- see link on Pg 5)

SHARED CARE PLAN CORE COMPONENTS

An example of a shared care plan has been provided with the shared care practices and collaborative planning protocol. It is not essential to use the example provided however it is expected that the core elements of a shared care plan are utilised in the development of a document.

The consumer's shared care plan will consist of the following core components:

Individual Recovery Plan-

- An overview of the Consumers' current situation, their strengths, their personal values, and how these may inform their future life vision.
- The Consumers' goals as prioritised by the individual and associated strategies to achieve these goals, and the supports required
- Articulation of the roles and responsibilities of all parties involved in the shared care plan.
- A list of all participants to the plan and indication of consumer consent for sharing of information.

Wellness Plan-

- Overview of consumers key stressors, early warning signs, key self management strengths, natural supports and effective coping and relapse prevention strategies
- Support plans pertaining to those who may be dependent upon the Consumer in times of relapse eg: children, pets….
- Advanced directives

Safety Assessment & Management Plan-

- Safety assessment is an ongoing process of observation and critical thinking to ensure the safety of consumers and those who support them.
- Each member of the shared care team will have valuable insights to contribute to the boarder understanding of others in the shared care team.
- Each member of the shared care team should be aware of identified safety issues and management strategies to promote consistency in practice and ensure all parties are working together to achieve the same goals

The development of a shared care plan will be predominately informed by resource tools or any other processes that are identified by the Consumer as being meaningful. This may mean the use of tools/ resources that are particular to only one of the services involved. This is not to be considered

a barrier, but a consideration for the shared care team about how this can facilitate completion of any service/ agency specific documentation requirements.

Consumer Consent for commencement of Referral and Initiation of a Shared Care Plan

When a worker (Community Mental Health practitioner/ AOD Practitioner/Support worker **and/or** clinical Case Manager) identifies that a Consumer is/will be shared between services the following issues should be discussed and the consumer's consent obtained:

- The opportunity to develop a shared care plan and consent to this.
- Potential referral and consent to this.

Where a consumer **does not consent** to the sharing of their plan or elements of it and suitable encouragement - and exploration of obstacles and benefits to shared care planning are explored with the consumer - then staff should document this on the Shared Care Plan and in the consumer's case notes and consult with their line managers.

1. **Initial Shared Care Plans for new consumers to shared care (newly referred to one or more services)**

a. It is the responsibility of the referring agency (given they have a current relevant history/ relationship with the consumer) to organise the initial shared care planning meeting within 8 weeks of the consumer being identified as is in shared care.
b. An 8 week timeline allows all agency staff to come to the meeting having had meaningful discussions with consumers about their recovery goals, wellness planning and associated safety and management plans
c. An allocated Planning Co-ordinator is appointed to ensure the regular ongoing review of the shared care plan occurs however it is understood that any member of the shared care team can initiate communication or request a review to ensure effective cross service communication occurs.
d. When the shared care plan is developed or reviewed it must be signed by the consumer and the allocated planning coordinator. A copy of the plan should be sent to all support staff that have been consented to by the consumer.

2. **Ongoing Review of Shared Care Plan**

- Any party who is involved in the shared care plan arrangement can initiate a review of the plan.
- Joint review meetings, which will include all relevant staff/ agencies involved in the shared care team will be held at a minimum of 3 monthly or sooner as required to review the shared care plan. These will be arranged and facilitated by the identified Planning Coordinator.

- At each review, the relevant contacts and details of the shared care plan will be updated by the participating staff members in collaboration with the Consumer, Carer and any relevant others.
- Any previous documents (IRP, wellness plans and safety management plans) should be utilised to support discussion in relation to the development of a current shared care plan.

- Cross sectoral best practice principles should be adopted whenever a shared care plan is to be reviewed. Such principles include :
    - Area Mental Health Service advises of mandated clinical review date to enable a shared care team review to occur prior to the allocated date and thus allow the clinician to provide collaborative feedback at the clinical review.
    - Area Mental Health Service Clinician invites other parties to the plan to the Clinical review to participate in collaborative forward service planning for the consumer.
    - Planning Coordinator /AOD Practitioner/Community Mental Health Practitioner/Support Worker invite the Area Mental Health Service clinician to the designated review to participate in collaborative forward service planning for the consumer.
- The method of regular ongoing contact is agreed upon by the Shared Care Team which may include face to face/email/telephone or teleconferencing. Regular communication about changing support needs is essential to assist the consumer to achieve their individual goals.

3. Transfer of Care upon Exit of Consumer from one of the agencies involved in the shared care plan

- The aim is to support the consumer during times of transition and assist remaining services in their service provision.
- The shared care team is informed and a meeting arranged by the agency considering discharge/ exit.

- Joint exit plan will be developed between the consumer and the exiting service, whilst keeping the shared care team members informed of plans, referrals being made and to confirm exit/transfer plans.

- Each remaining service, and the consumer, will review and revise the shared care plan accordingly.

- Please Note: The exit process should be transparent amongst all service providers and therefore it is not acceptable to inform the shared care team post the consumer having been discharged/ exited. As much notice as possible will be given to other services of planned discharge dates and any changes to those timelines.

4. Conflict resolution between services

- If any question, difference or dispute arises between the parties, dispute resolution in the first instance is the responsibility of relevant program managers, who will refer any unresolved issue to their representative on the Eastern Mental Health Service Coordination Alliance Committee.
- Where agreement cannot be reached by the Eastern Mental Health Service Coordination Alliance Committee the Chief Executives of the organisations/sector representatives that are party to the Agreement will agree on a method of resolution to apply to the question, difference or dispute.

5. Documentation

Sharing information between service providers

- When consent ***is given*** by the consumer for the sharing of information – Information for the purpose of the ongoing treatment of the consumer must be shared

- When consent ***is not given*** by the consumer for sharing of information – that information may still be shared if it aids the provision of ongoing treatment and/or identifies current risk/safety issues. Consider what is reasonable to be done with consumer information in order to provide suitable health care.

Sharing of documentation with the Service recipient

- The Shared Care Plan is provided to the consumer at initial development, at each review and upon request by the consumer.
- All other documentation contained within the Clinical Services medical record is only released to the consumer via application to the Eastern Health Freedom of Information officer.
- All other documentation contained within the CMH/PDRSS/AOD client file is only released to the consumer according to the information release policy of that agency.
- It is a courtesy to the author to inform them if information is being released to the consumer.

References:

Confidentiality under the Mental Health Act 1986, Mental Health Branch, Mental Health and Drugs Division

Health Records Act 2001 **(Vic)**. Office of Health Services Commissioner

Information sharing between area mental health services and psychiatric disability rehabilitation and support services Chief Psychiatrists Guideline, Mental Health, Drugs and Regions Division Victorian Government Department of Health

Links:

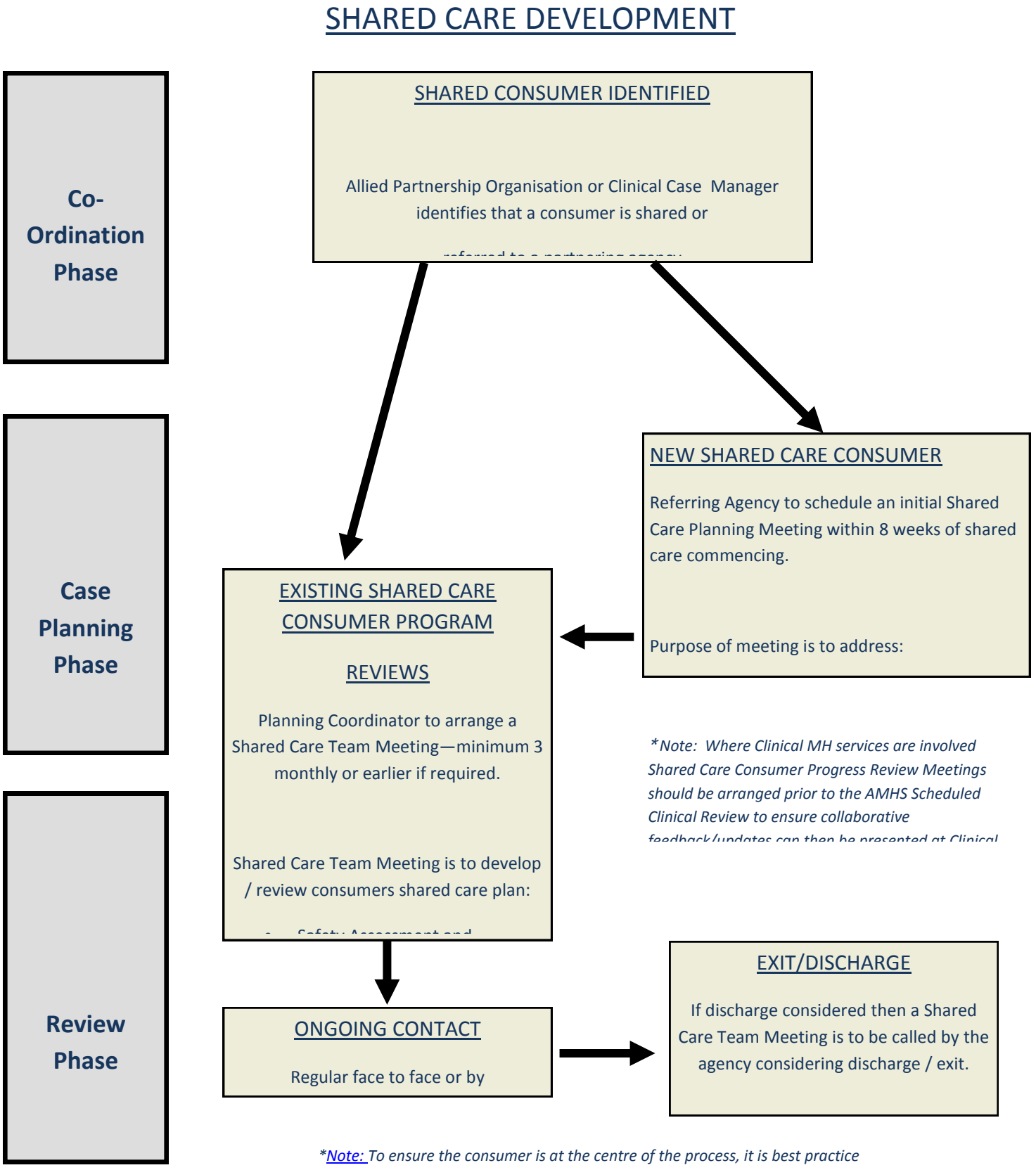
www.health.vic.gov.au/mentalhealth/pmc/confidentiality.pdf

www.health.vic.gov.au/hsc/downloads/hppextract.pdf

www.health.vic.gov.au/mentalhealth/cpg/information_sharing.pdf

http://www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm

6. Flow Chart outlining procedure



Appendix F – Individual Recovery Plan Example

INDIVIDUAL RECOVERY PLAN (IRP) (Sheet 1 of)					
Personal INFORMATION: GIVEN NAME/S FAMILY NAME (BLOCK LETTERS) of Consumer Address: Date of Birth:				**Planning Coordinator/ Support Facilitator:** Service: Telephone: **CLINICAL Mental Health TEAM:** Psychiatrist: Treating doctor: Case manager : Service: Address telephone:	
OTHER PARTIES TO THE PLAN:			**Consent**	**Recovery Dimension**: Each Recovery Dimension outlined should be relevant to the individual needs of the person who owns the plan. The plan owner requires opportunity to preference their own needs Please refer to your local **Needs Assessment Tool Domains** to define issues & areas of your life you may like to change/learn about or would like some help with:	**Identified Areas of Strength:**
General practitioner:		telephone:			
Private psychiatrist:		telephone:			
Nominated carer/s:		telephone:			
Community Mental Health Practitioner:		telephone:			
AOD Practitioner:		telephone:			
Other (Specify):		telephone:			
Other (Specify)		telephone:			
Other (Specify)		telephone:			

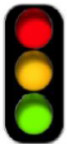
Recovery Dimension	Collaborative Goal	Date entered	Actions to be taken	PERSON(S) RESPONSIBLE	Progress

……Date: …/…/……	……Date:…./…/……
Plan owner's signature	Planning Coordinator's signature
……Date: …./…./…	Scheduled Review Date: …./…./…..
Nominated Carer's signature	

Copy of Plan sent to the following:	Consent* (Y/N)		Consent (Y/N)
_____ _____ Date: ..../..../.... (name) (role)		_____ _____ Date: ..../..../.... (name) (role)	
_____ _____ Date: ..../..../.... (name) (role)		_____ _____ Date: ..../..../.... (name) (role)	
_____ _____ Date: ..../..../.... (name) (role)		_____ _____ Date: ..../..../.... (name) (role)	
_____ _____ Date: ..../..../.... (name) (role)		_____ _____ Date: ..../..../.... (name) (role)	
_____ _____ Date: ..../..../.... (name) (role)		_____ _____ Date: ..../..../.... (name) (role)	

*Indicate if consent to share the plan has been obtained

Appendix F – Wellness Tool example



My Wellness Plan for Mental Health and Substance Use Concerns

Name: **Date:**

0

My RED light signs – Mental Health

- I know things are really not going well with my mental health when I notice that:
- When I notice things are really not going well with my mental health, the things I need to do are:

More: Less:

My RED light signs – Substance Use

- I know things are really not going well in the area of substance use when I notice that:
- When I notice things are really not going well in the area of substance use, the things I need to do are:

More: Less:

5

My AMBER light signs – Mental Health

- I know things are not quite right with my mental health when I notice that:
- When I notice things are not quite right with my mental health, the things I need to do are:

More: Less:

My AMBER light signs – Substance Use

- I know things are not quite right in the area of substance use when I notice that:
- When I notice things are not quite right in the area of substance use, the things I need to do are:

More: Less:

10

My GREEN light signs – Mental Health

- I know things are going well with my mental health when I notice that:
- When I notice things are going well with my mental health, the things I need to keep doing are:

My GREEN light signs – Substance Use

- I know things are going well in the area of substance use when I notice that:
- When I notice things are going well in the area of substance use, the things I need to keep doing are:

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Eastern Metropolitan Region Dual Diagnosis Working Group & Consumer and Carer Advisory Council

MH – Mental Health **SU** – Substance Use **Note:** Indicate how you are going using these codes on the scale

Appendix G – Safety Assessment and Management Plan example

easternhealth
Mental Health Program

Clinical Risk Assessment and Management

UR Number: ..... MH Number: .....

Name: .....

Address: .....

Telephone: ..... D.O.B.: ..... M / F

(AFFIX PATIENT LABEL or RECORD PATIENT DETAILS)

Contributory Risk Factors	Description of Risk/s
1. Historical Factors: Prior history of self-harm, suicide attempts, violence, forensic history, family history. (this includes any repetitive patterns of behaviour)	
2. Dispositional Factors: Gender, age, socio-economic status, intellectual functioning / acquired brain injury.	
3. Contextual Factors: Life situation, substance abuse, stressors, coping skills, social supports, emotional state, threats, access to weapons vehicle safety/driving.	
4. General Vulnerability: Risk-taking/dangerous behaviours, memory deficit, confusion/disorientation, intrusive behaviour, sexual disinhibition, passivity, drug use/abuse, lack of insight.	
5. Risk to Self / Self Harm: Recent acts of self harm, current plans to self harm, active suicidal intent, availability of method, preparations for death, depressed / flat mood, shame, hopelessness, social withdrawal, delusional content, poor emotional regulation, lack of social supports, hazardous substance use patterns.	
6. Risk to Others: Recent episodes of violence, current plans for aggression or hostility, hostile or aggressive affect, violent fantasies & cognition, command hallucinations, delusional content, neglect of dependents, poor impulse control.	
7. Physical Vulnerability: Acute illness, chronic illness, altered activity levels, ADL deficit, history of falls, poor skin integrity allergies/sensitivities.	
8. Treatment related factors: Level of compliance, capacity to engage, intent to abscond, refusal of treatment.	

Potential Interventions	Risk Management Strategies
A) Observation / Contact:	
B) Environmental Strategies:	
C) Psychosocial Supports:	
D) Medication Management:	
E) Referral/Admission/Transfer:	
Next Scheduled Review Date: Time:	

Name:	**Signature:**	**Designation:**	**Date:**
Name:	**Signature:**	**Designation:**	**Date:**
Date of Team Review:	**Consultant/Registrar/HMO Signature:**		

RISK ASSESSMENT & MANAGEMENT MREH 205.2

Revised December 2004 Cat no. ####

CLINICAL RISK ASSESSMENT AND MANAGEMENT Guidelines for Use

The cues in the following descriptions of risk factors and potential interventions are neither prescriptive or exhaustive.

ISSUES TO CONSIDER

1. HISTORICAL FACTORS:
Significant factors from the past that may influence current behaviour.

Violence: – refer to items 5 & 6

Forensic: History of criminal charges or behaviour. eg assault convictions.

Family: history of physical or emotional abuse, mental illness, drug/alcohol abuse, suicide

Repetitive patterns of behaviour: eg Is there a chronic pattern (over 6 months or more) of self harm / suicide attempts, gambling, impulsivity.
Is there any change in this behaviour?

2. DISPOSITIONAL FACTORS:
Genetic or environmental factors that are known to contribute to risk

Gender:
Males 18-25 may be higher risk of aggression / violence, suicide.
Females 15-17 may be higher risk of serious self harm / suicide

Socio-economic: unemployed, homeless, debt ridden.

Diminished intellectual functioning:
This is often associated with Intellectual Disability or Acquired Brain Injury leading to:
- lowered frustration tolerance,
- lack of understanding or confusion,
- difficulties expressing needs

3. CONTEXTUAL FACTORS:
Current social and emotional factors that affect behaviour.

Life situations:
Any current crisis?
Any recent loss of significant other?

Alcohol or Drugs: Does physical examination and/or history show signs of drug / alcohol use / abuse?
Is withdrawal likely? Potential for intentional / accidental overdose?

Relationship difficulties:
Are there any current issues with partner, children, parents, friends, employer, neighbours, others?.

Social supports: What social supports can the client identify? Are loneliness, withdrawal, isolation issues currently?

Environment:
Is the immediate environment safe?
Does person have access to weapons?
Are dogs / dangerous animals present?

4. GENERAL VULNERABILITY:

Dangerous Behaviours:
Arson, unprotected sex / promiscuity, criminal activities.

Delusions: Does the patient believe they have special powers / wealth? Are there nihilistic thoughts influencing behaviour or ideas of being controlled by another person or object?

Disorganisation: Can the person function in an organised way, completing ADL's in a rational way?

Memory deficit: How well is the patient's short term/long term memory operating? Will patient become easily lost or forget medication?

Neglect of Self / Vulnerability (Judgement Deficit): How well is the person able to make decisions that reflect adequate regard to personal safety? This may be in regard to personal / interpersonal safety, legal or financial decisions.

Orientation Deficit: Is the patient oriented in person, time and place?

Provocative Behaviour: Is the person intrusive, demanding, combative, sexually disinhibited or negative and likely to come to harm?

Wandering: Would wandering create a danger to self/others?

5. RISK TO SELF / SELF HARM AND
6. RISK TO OTHERS:

Self-Harm: Is the person expressing ideas of self-harm? With or without suicidal intent. eg cutting or overdose?

Delusions: Does the content of delusions indicate risk of self-harm, persecutory content that is increased by hospitalisation, or focused on other patients/staff?

Hallucinations: Do the hallucinations create sense of fear or persecution? Is the person responding to command hallucinations to harm self/others?

Suicidality: has person expressed ideas of suicide or behaviour indicating suicidal intent e.g.: plans, notes, will making: lethality of method, previous attempts, Sudden mood alteration**?**

Aggression: Is there a history of institutional aggression or coercive personality style? Is the patient currently exhibiting aggressive behaviour?

Homicidality: Has the person expressed ideas of killing/harming others? Is there identified victim(s)? Is victim known, been informed?

Neglect of Dependants: Does the mental health of the person make her/him unable to adequately care for dependants – children or elderly?

7. PHYSICAL VULNERABILITY:

Altered Activity: Has the patient's activity level increased to the extent of exhaustion? Has the patient's activity decreased to the extent that the person does not attempt to eat or drink, becomes constipated or is catatonic?

Acute Illness: Is there an acute physical illness? Is special treatment required?

Chronic Illness: is special management required? Risk of exacerbation by psychiatric treatment e.g. diabetes?

Disability/ADL Deficit: Does the person have a disability that prevents attention to ADL's?

Fluid Deficit: Is person dehydrated; electrolyte levels compromised, blood volume decreased?

Infectious Disease: Are there known infectious diseases present? Do these require special care?

Mobility: Does the person have balance, coordination, muscular, or neurological deficits that impact on safe ambulation or movement?

8. TREATMENT RELATED FACTORS:

Level of compliance: Is there a history of poor treatment compliance. Have they experienced significant side effects in the past?

Capacity to engage: Was rapport/trust easily gained? Is there a level of ambivalence to their treatment?

Intent to abscond: Has the person expressed intent to leave? Do they have insight into need for treatment? Is there a history of absconding?

Refusal of treatment: Does the person accept medication willingly; are IM / depot medications appropriate?

POTENTIAL INTERVENTIONS

A) OBSERVATION / CONTACT:
inpatient: joint activity with staff; increased frequency of observations; specialling.
community: increased contact frequency (telephone or face-to-face); engage family/ carers in ongoing monitoring.

B) ENVIRONMENTAL STRATEGIES:
modification of immediate environment (add / remove features identified as affecting risk); develop distraction activities move to a more restrictive environment.

C) PSYCHOSOCIAL SUPPORTS:
counselling, engagement in supportive carer/ community activities; behaviour modification plans.

D) MEDICATION MANAGEMENT:
assess medication adherence; assess if medication side-effects compounding risk or contributing to poor adherence; organise medication review; consider PRN medication.

E) REFERRAL/ADMISSION/TRANSFER:
where no effective strategies can be implemented, it may be appropriate to transfer care to a more 'acute' program in service, interagency communication.

Appendix H

Shared Care Audit questions

Question	Question criteria	Response values and skip logic
Q 1.	Does the consumer have a mental illness and is receiving assistance from two (2) or more services due to having multiple needs?	1=Yes; 0=No; NS=Not sure If Answer is No or Not sure-You have finished. If yes-go to Q. 2
Q 2.	Does the consumer have an identified G.P.?	1=Yes; 0=No
Q 3.	Has a Wellness plan been documented with the client?	1=Yes; 0=No
Q 4.	Has a safety assessment and management plan been documented with the client?	1=Yes; 0=No
Q 5.	Is the client receiving shared care from a group or team of health professionals who are working together to deliver coordinated care with the client, carer?	1=Yes; 0=No
Q 6.	Has this shared care been formalised into a care plan document (e.g. Individual recovery plan; service/ care coordination plan)?	1=Yes; 0=No; If answer is No-you have finished If yes, go to Q. 7
Q 7. (a)	Are there any service providers who have not been included on the Shared Care Plan (SCP)?	1=Yes; 0=No If No, go to Q. 8 If Yes, go to Q 7(b)
(b)	How many service providers have not been included on the SCP?	Insert number value e.g. 1, 2, 3, 4
Q 8.	The shared care plan includes the following **completed** elements (fields). Please answer Yes or No to each element	
(a)	Overview of the consumer's current situation	1=Yes; 0=No

Question	Question criteria	Response values and skip logic
(b)	Consumer's goals	1=Yes; 0=No
(c)	Strategies or actions	1=Yes; 0=No
(d)	Roles and responsibilities of all parties involved	1=Yes; 0=No
(e)	List of participants involved in the development of the plan	1=Yes; 0=No
(f)	Planning Coordinator or Support Facilitator identified	1=Yes; 0=No
(g)	Planned review dates and agreed form of communication	1=Yes; 0=No
(h)	Consumer consent documented	1=Yes; 0=No
Q.9	Comments:	Text field

Audit criteria-Shared Care.xls

Microsoft Excel-Audit data collection tool example