Mood
Academic Clinical Unit
Metro South
Addiction and Mental Health Services

Model of Care
Models of care set the standard for care

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Acknowledgments

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Abbreviations

MSAMHS     Metro South Addiction and Mental Health Services
ACT        Acute Care Team
ACU        Academic Clinical Unit
ABF        Activity Based Funding
ATAPS      Access to Allied Psychological Services
APHRA      Australian Health Practitioner Regulation Agency
CSCF       Clinical Services Capability Framework (CSCF V3.1)
CIMHA      Consumer Integrated Mental Health Application
CALD       Culturally and Linguistically Diverse
CM         Case Manager
ED         Emergency Department
HONOS      Health of the Nation Outcome Scale
MDT        Multidisciplinary Team
MSHHS      Metro South Hospital and Health Service
MoC        Model of Care
PSP        Principle Service Provider
QHEPS      Queensland Health Policy Intranet Site
Our vision
Provide our community excellence in consumer and family-centred, integrated services across the continuum of addiction and mental health care.

Our mission
Demonstrate exceptional care to consumers experiencing addiction and/or mental health problems to reduce the burden of disease and to integrate care with our key health partners.

Our core values
Metro South Addiction and Mental Health Services has six core values that define and determine how we embrace our day-to-day work.

1. **Courage**
   To challenge what is the status quo and lead change.

2. **Leadership**
   To guide with purpose and direction through acceptance of responsibility and accountability for the services we provide.

3. **Team work**
   We work in a supportive, transparent, responsible and answerable manner.

4. **Respect**
   We treat consumers, families, carers and staff with equality and consideration.

5. **Integrity**
   We demonstrate honesty, loyalty and sincerity.

6. **Caring for people**
   To help, assist and guide individuals to achieve their goals.

Our service culture is based on the focused delivery of care to consumers and their families and carers, within a framework that encourages hope and the building of resilience.

**Underpinning documents**
Service provision is based on principles outlined in (but not exclusive too) the following reference documents:

- Fourth National Mental Health Plan.
- National Practice Standards for the Mental Health Workforce 2013.
- National Standards for Mental Health Services 2010.
- Clinical Services Capability Framework (v3.1)
- Queensland Health Strategic Plan 2012-2016.
- Mental Health Act 2000.
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Foreword

“In an era of consumer choice, the voice of mentally ill people is ignored. They should be made a ‘treatment offer’, as others are, and this should be open to negotiation, except where the nature of their illness makes that impossible.”

Jeremy Laurance (Health Editor of The Independent) 2014.

Metro South Addiction and Mental Health Services (MSAMHS) is responsible for implementing clinician-designed Models of Care and other clinical innovations. These Models of Care reflect the needs of mental health consumers and are based on ‘best’ evidence approaches to health and wellbeing service provision.

The implementation of formalised Models of Care is relatively new within MSAMHS, particularly when linking the Model of Care to ‘clinician activities’.

The aim when implementing the Models of Care is to achieve a balance between improving consumer outcomes and ensuring efficient and effective use of specialist mental health resources.

The Model of Care has been prepared by and for the Mood Academic Clinical Unit clinicians to:

- articulate and implement the objectives, principles and values of MSAMHS
- provide high-level explanation of key service provision elements
- describe how service provision is linked to economic indicators
- describe how services are integrated across the specialist mental health and mainstream healthcare system.
Part 1:  
Mood Academic Clinical Unit

1.0 Introduction

Metro South Addiction and Mental Health Services (MSAMHS) is a specialist area of healthcare that promotes optimal quality-of-life for consumers with mental ill-health. The specialist services are concerned with the assessment, diagnosis, monitoring and treatment of consumers who have a mental health disorder characterised by a **clinically-significant** disturbance of thought, mood, perception, memory and/or behaviour.

Specialties within MSAMHS address the needs of a broad mix of consumer types across the entire age spectrum (children, adolescents, adults and older persons). A consumer’s need for specialist service provision can be short, medium, long-term or intermittent, and often spans various levels of care and service areas.

The services of MSAMHS are delivered by the specialist Academic Clinical Units (ACU). The Mood ACU is one of the key specialist providers in the integrated MSAMHS. Each ACU is charged with meeting service and funding efficiencies relevant to their specialty. Besides the Mood ACU, other specialist ACUs include:

- Resource and Access Services (RAS)
- Psychosis
- Older Adult
- Child and Youth
- Consultation Liaison
- Rehabilitation
- Addiction Services
- Transcultural Mental Health.

The Mood ACU routinely attends to the special needs associated with the mental health of:

- Aboriginal and Torres Strait Islander peoples
- people of culturally and linguistically diverse (CALD) backgrounds
- people living in rural and remote areas
- people with a comorbidity or complex needs - this may include, but is not restricted to, consumers with a mental health diagnosis as well as:
Individuals access and enter MSAMHS through the RAS ACU and are then transitioned to the Mood and other specialist ACUs based upon their needs, age and their primary diagnosis (Diagram 1).
1.1 Service specifications

Core services underpin the Mood ACU and the individual consumer’s recovery, these include:

- multidisciplinary assessment and specialised interventions by mental health professionals; a designated care coordinator/case manager; documented frequent case reviews that include outcome measurement; consumer and carer support and education; all levels of relapse prevention programs/services; evidence-based treatment interventions that include vocational assessment and support, socialisation, nutrition, exercise; consultation-liaison with other healthcare and related services; peer support worker engagement; extended-hours service; and, service delivery transfer to mainstream and other healthcare services
- service delivery to the highest risk/complexity voluntary and involuntary mental health consumers
- the development and use of care pathways that inform the assessment, diagnosis, monitoring, treatment, evaluation, ongoing care, referral and transfer of consumers
- any interventions required in the management and containment of violent and/or self-harm behaviours
- episodes of care being ‘comprehensively’ documented in the Consumer Integrated Mental Health Application (CIMHA)
- engaging consumers, their family and carers
- promoting and ensuring continuity-of-care

Under the Clinical Services Capability Framework (CSCF) V3.1 the workforce requirements support:

- services being delivered by a multidisciplinary team that includes the following professionals and supports:
  - psychiatrists and other medical doctors
  - nursing
  - social work
  - psychology
  - occupational therapy
  - peer support workers
  - transcultural advisors
  - administration staff.
- clinicians employed to the Mood ACU demonstrate high levels of clinical expertise in the assessment, treatment intervention and evaluation of consumer care
- clinicians are engaged in ongoing education and training in clinical and safety programs relevant to the clinical practices of the Mood ACU
clinicians participate in clinical practice supervision with clinician/s who are trained/ experienced in service delivery relevant to the consumer group

clinicians hold professional qualifications and, if required, are currently registered with the Australian Health Practitioner Regulation Agency (APHRA)

clinicians access on-demand interpreter services (e.g. language and sign language) if required

clinicians access support services and if possible service providers as required with expertise in:
• Aboriginal and Torres Strait Islander mental health
• transcultural mental health
• dual diagnosis (e.g. mental health disorder plus alcohol/other drug disorder)
• consumer and carer support needs (peer support workers).

The service specifications are an ambitious set of practice expectations - they are intended to be accessible at all times. However, they are not routinely offered to all consumers. For each consumer a treatment plan is tailored to their needs, which may call upon just some of the service specifications.

To determine which service specifications are delivered, choices have to be made, by the consumer themself or in consultation with support and other staff. This requires a valid and useful needs assessment, coordination and planning. The services chosen are to be supported by rating scales and other outcome measures which the case manager will use to guide clinical practices.

The specifications also bring to light the clashes clinicians and consumers sometimes encounter. It occasionally happens that what the consumer wants is not what the consumer needs. In such situations, these are discussions that must occur to air and view the concerns consumers, families and carers have, prior to arriving at the actions that best suit the wellbeing of the consumer.

1.2 Funding

It is important clinicians recognise funding for the Mood ACU, like all other ACUs, is reliant upon clinicians accurately recording their service activity (recording episodes of care, admissions, appointments, case reviews, assessments and treatment interventions - including outcome measures (serial HONOS) for each and every consumer).

A consumer of the Mood ACU will attract funding based upon either an assessment or treatment service provided (Diagram 2):
For a package to be considered valid it must meet the following minimum requirements:

1. An **assessment package** must include a provision of service that includes an assessment or intake intervention. This includes triage/ initial assessment, mental status assessment, comprehensive mental health assessment, or intake triage.

2. A **treatment package** must include:

   - a current diagnosis. Diagnoses must be reviewed and confirmed by a psychiatrist and/or multidisciplinary team every 91 days (note: diagnoses entered in the CIMHA outcomes module are not considered)
   - a provision of service in which the consumer participates in person or by video conference
   - a provision of service that includes a multidisciplinary case review or other review. This is not required for packages that are less than 91 days in length
   - a valid outcomes collection from the National Outcomes Casemix Collection (NOCC). As per the NOCC protocols, this is not required for Consultation Liaison packages or consumers aged three or below.

Packages not meeting the above criteria are not considered as valid (and will not attract funding to the Mood ACU).

### 1.3 Locations

The Mood ACU teams are based in the following hospital catchment areas:

- Logan-Beaudesert
- Redlands and Bay Islands
- Princess Alexandra.
1.4 Consumers

Consumers accessing the Mood ACU are a targeted population with special care needs and may demonstrate extreme comorbidities and/or indicators of treatment resistance. The Mood ACU is capable of providing short- to long-term or intermittent non-admitted mental health care to the highest risk/complexity voluntary and involuntary adult mental health consumers aged 18 years to 65 years, with an ICD-10 mental health diagnosis associated with:

- depressive disorder
- anxiety disorder (including trauma-related disorders and obsessive compulsive disorders)
- bipolar disorder
- eating disorder, and/or
- personality disorder.

The Mood ACU does not routinely provide services to consumers whose primary presenting problems are:

- requests for medicolegal reports alone
- alcohol and drug problems
- intellectual disability
- social or domestic problems.

1.5 Care philosophy

The Mood ACU service delivery is informed by the values inherent in the recovery model, services are:

- consumer-oriented (rather than illness-oriented)
- involve the consumer in the planning and implementation of services
- show respect for self-determination and choice
- focus on social inclusion, health and resilience.

The Mood ACU addresses the nature of how consumers with serious mental ill-health are engaged and involved in their treatment.

1.6 Core service components

The Mood ACU provides time-limited services that include (but are not limited to):

- assessments, treatments and interventions
☑️ family, carer support
☑️ education of medication and concordance
☑️ recovery management skills (including shared decision-making, relapse prevention, pursuit of personal goals, understanding of mental ill health)
☑️ specific coping skills (including cognitive behaviour therapy and stress management training, such as relaxation training and grounding)
☑️ linking consumers with community support organisations including: housing, employment services, Centrelink financial supports, NGO and peer support workers, GPs and other specialist medical and non-medical officers, and
☑️ wellness advocacy (including physical healthcare, work/school/social functioning and independent living).

1.7 Core service elements

1. Integrated care

Within the Mood ACU, most of the care interventions are carried out by members of the team. In the integrated Mood ACU team the interventions needed are divided among the specialist team members.

2. Multidisciplinary team

The services are delivered to the consumer by an integrated, multidisciplinary team. The psychiatrist, the nurse, the social worker, the psychologist, the occupational therapist, the addiction workers and the support workers each have their own expertise and perspective. Because they work together and meet regularly, they develop a joint vision and style. The different disciplines represent different kinds of solutions for daily problems; at the case review meetings, the team discuss the various interventions and decide on the order in which they will be offered.

3. If required, shared case loads

Instead of having individual caseloads, the whole team shares cases, so that different members of the team visit consumers at home or support them in other ways. This team care means that the consumer receives intensive care and treatment from several or all members of the team at different times, if necessary.

4. Clearly defined model

The Mood ACU delivers a consistent service model with working procedures. However, the program is not a straitjacket. The team and its members have enough room to develop their own style.

The distinctive identity of the team is also important; it means that the specific expertise and strengths of the team members are better utilised.
The Mood ACU teams must also be able to connect with the community or region in which they are working; they have to be willing to respond to local problems and able to collaborate with local services.

5. Good coordination

The Mood ACU service delivery model enables a team to deliver specific services, however the team must be well coordinated. Decisions have to be made about various interventions; what should be done first, what should be done later. Coordination takes place at the case review meetings. Good coordination is essential not only for treatment and supervision, but also for the many external contacts the team has to maintain: ringing up family members, making contact with neighbourhood bodies, etc.

6. Outreach

Outreach means care outside of the community mental health clinic; it means home visits, care or counselling relating to social activities, visiting the consumer at a police station and if necessary caring for homeless people on the streets.

Home visits and outreach also mean a lot for the relationship between consumer and clinician. Care practitioners have to ‘blend in’ with the consumer’s territory. They are no longer in charge (as they are at the hospital or community mental health clinic); they have entered the other person’s territory, which helps them to accept that other person as they are and which leads to different dialogues.

1.8 Service framework

The service framework guides the activities of the Mood ACU clinicians. Essentially the framework emphasises the benefits of combining pharmacological treatments with behavioural, social and lifestyle interventions. It reflects a ‘biopsychosocial’ approach that includes all aspects of consumer care across the continuum-of-services.

The Mood ACU treatment and intervention setting is determined by the consumers mental state and safety, which determines the phase of service delivery. There are three service delivery phases, ranging from high intensity to low intensity, each depicting the primary role of the specialist mental health service (Diagram 3).

![Diagram 3: Service Framework]
Consumers enter the service when their service needs are highest (specialist healthcare assessments, inpatient care, crisis management, pharmacological interventions, specialist psychosocial interventions) and transition to the lesser service intensive mainstream healthcare and other interventions as quickly as possible. The role of the clinical leader and case manager is crucial throughout this process, as they must routinely monitor and review the consumers progress to establish the appropriate ‘assessment’ and ‘treatment’ packages that will transition the consumer to community and primary care services.

1. Acute phase

Specialist mental health care

The specialist mental health service focuses on consumer safety and targets:

- self harm, suicide, aggression
- extreme affects, grossly disorganised cognitions, and impulsive and disruptive behaviour
- anxiety, panic, trauma, distress
- physical health (low/high BMI).

Specialist service delivery includes:

- inpatient services
- specialised treatment programs for specific disorders, e.g. eating disorders, affective regulation, dual diagnosis, treatment resistant affective disorders, and pregnant women with a mental health disorder (other than schizophrenia)
- intensive outreach crisis and ongoing ambulatory care
- alternative care to inpatient services (home hospital)
- family/carer support.

2. Stabilisation phase

Specialist mental health care + community services + primary care

The consumers symptoms are stabilised and care includes community and primary care service providers. During this phase, service provision may include:

- specialist services (integrated case management and condition specific interventions, such as Cognitive Behaviour Therapy, Dialectic Behaviour Therapy, Acceptance Commitment Therapy)
- talking treatments (counselling services, peer support, advice groups).
- Management of comorbidities (e.g. primary care and other services support better physical healthcare outcomes)
- coping skills/stress management training
- reactions to illness/psychoeducation and medication concordance
Model of Care

- social/family/carer support
- community adjustment support (work, education, accommodation, finances, peers, friendships)
- intensive community care (step down services, with the support of peer support workers and non-government organisations)
- GP services
- ATAPs referrals (e.g. specialist psychology services).

3. Stable phase

Limited specialist mental health care + community services + primary care

The consumers symptoms are stable and care is transitioned to alternate community-based care providers. During this phase, care may include:

- housing, finances, activities of daily living, healthy lifestyles
- peer work / Coping supports
- socialisation/exercise/diet
- counselling/case management
- occupational/vocational/educational
- culture/religion
- GP referral, ongoing routine investigation and support.
- ATAPs and other service providers.

The specialist mental health service offers advice, consultation and training services when supporting mainstream service delivery.
Part 2:

Care in the community

2.0 Introduction

Underpinning the Mood ACU community service program is the Addiction and Mental Health Services Strategic Plan 2014-2017. The four strategic priority areas guide the day-to-day consumer focused activities of the Mood ACU (Diagram 4).

Diagram 4: Consumer Focused Activities

The Mood ACU community care program asserts that symptoms and functioning are improved when the consumer systematically obtains the right services, at the right time, in the right place by the right providers. Part 2 of the Model of Care, Care in the Community, looks at the key community services offered to consumers, carers and families.
The key principles that guide the Mood ACU service provision ensures all new cases having:

1. An assessment for severity of illness and a needs assessment is completed at intake.

2. The intake screen incorporates the NOCC measures as well as the Mood ACU specified outcome measures (Appendix 1).

3. The assessment (distinct from the intake assessment) evaluates the consumer’s functional capabilities and needs.

4. The intake and assessment phases must investigate comorbidities.

5. A written plan must be developed (with the consumer, family and carers whenever possible).

6. Plans are shared with the consumer (and carers and families, with the consumer’s permission).

7. Specialised therapies are initiated within 2-3 weeks of the consumers intake screen contact.

8. Consumers and their families or carers are also provided with the following additional information:
   - how to access the 24 hour 7 day crisis care
   - how to access acute care (including inpatient care)
   - how to obtain nonmedical crisis support
   - how to obtain at home support
   - how to access community based rehabilitation and support
   - how to obtain addiction service support
   - how to access non-mental health treatments (diet, exercise, socialisation)
   - how to access employment and education opportunities
   - how to access supported / affordable housing.

The Model of Care emphasises a community focus, including integrated service delivery involving families, carers, GP and primary care services, private practitioners and organisations across the community sector.

The majority of service provision will occur in the consumer’s home, at a community clinic, or general practice or other nominated place within the community. Clinicians emphasise continuity-of-care, paying particular attention to the closure of service gaps and maximising opportunities for recovery.

The Mood ACU may under certain circumstances provide consultation and liaison
services to GP and other services. Similarly, the service may also provide or co-
provide short term follow-up to consumers transferring from one catchment area or
health service to another.

### 2.1 Core community activities

#### 2.1.1 Referral

**Description**

Referral to the Mood ACU often follows other healthcare interventions (e.g. RAS
services, ED presentations, inpatient services, primary care services, community
service care and other services). Collateral information is gathered to reduce service
duplication and wasted time and effort, whenever possible.

The referral pathway into the Mood ACU is illustrated in Diagram 1. Referrals on
the standard MSAMHS referral form are forwarded to the local Mood ACU email
account.

Referrals will originate from the following sources:

- 1300 MH CALL (triage)
- acute care teams (mobile outreach teams)
- hospital ED; and/or
- inpatient services.

Referrals however, may also include self and assisted referrals, for example:

- A doctor-to-doctor transfer is initiated (e.g. Hospital Health Service to Hospital
  Health Service, ACU to ACU).
- A past consumer may re-contact the local Mood Team; and
- A GP may seek advice and assistance fearing a relapse for a previous consumer
  of the service.

**Procedures**

- Mood ACU receives the referral (the duty intake officer and administration
  officer routinely monitor and manage the email account, printing hardcopies for
  the team leader).
- Team leader screens the referral for appropriateness and priorities.
- Referral is discussed by the clinical team and a clinician assigned to provide
  feedback to the referrer, continue the screening process if needed, or arrange
  an initial clinical interview with the consumer to conduct further assessment and
discuss treatment options.
- If a person is referred direct to the Mood ACU, this information is provided to
  1300 MH CALL (Resource and Access Service ACU (RAS)) – if appropriate.
The time taken from the referral being received to the consumer being seen is routinely monitored by the team leader.

Time-frames, from referral to initial assessments, will be formulated according to the consumers clinical needs (consumers at greater risk are assessed more urgently). In the event the initial assessment is not undertaken within the stated time-frame, a clinical review by a senior clinician with an updated risk assessment is documented on CIMHA.

2.1.2 Intake

Description
Consumers referred to the Mood ACU shall complete an Intake assessment that includes screening for comorbidities to identify and target alcohol and drug use, physical ailments, clinical risk, and so on.

Procedures
Intake ensures a consistent and coordinated approach to identify, assess and to provide appropriate services for consumers within the Mood ACU. Intake resources shall include combinations of the following and should be documented in the electronic record - CIMHA:

- psychiatric and medical history
- psychosocial history
- mental state examination
- physical examination
- clinical risk assessment
- case formulation and diagnosis
- initial treatment goals and intervention plan
- national outcome measures (when applicable)
- Mood ACU outcome collections (Appendix).

2.1.3 Assessment

Description
A comprehensive mental health assessment follows the initial screening procedure and aims to holistically identify and determine the individual consumer’s needs (Diagram 5).

Clinicians begin the assessment by first identifying the consumers needs, then systematically focusing on factors relevant to the consumers healthcare (focusing first on factors proximal to the consumer, then those that are distal).
Diagram 5: Biopsychosocial Assessment Model

Assessment shall include:

1. Symptoms (consumer needs, issues and symptom impact)
   - signs and symptoms of psychopathology (the presence of a mental disorder)
   - symptom frequency and duration
   - capacity to understand and the memory to comprehend in a general way the situation in which the consumer finds themself, and the nature and purpose and consequences of their actions
   - physical wellbeing
   - risk to self/ risk to others
   - comorbidities (substance abuse/misuse, physical healthcare problems, disabilities).

2. Life events
   - historical factors/background
   - stressful current situation
   - positive recent life events
   - negative recent life event (trauma)
   - positive past life events
   - negative past life events (trauma).

3. Psychosocial needs
   - coping skills
   - adjustment ability/resilience
   - reaction to illness
4. Couple relationship needs
- historical factors/background
- relationship adjustment
- positive emotional climate
- negative emotional climate.

5. Family relationship needs
- children/ parenting role / adjustments / behaviour
- family size
- historical factors/ background
- positive family climate
- negative family climate.

6. Peer relationship needs
- historical factors / background
- association with positive peers
- association with negative peers
- need for peer support

7. Socioeconomic needs
- accommodation
- education
- occupation
- income / finances.

8. Community needs
- social supports
- access to services / resources.

9. Culture / Faith:
- connection to culture
- connection to faith.

10. Work / educational climate
- positive work / educational climate
- negative work / educational climate
11. Neighbourhood quality:
- positive neighbourhood influences
- negative neighbourhood influences.

**Procedures**

- Routine assessments are timely, reflecting the clinical needs of individual consumers. Efforts are made to ensure 100 per cent of all assessments identify consumer, carer and family needs, which includes the completion of the standardised outcome measures, as per the recommended response timeframe (Appendix).
- Current risk assessments are conducted at assessment, routinely at 90 day reviews and as clinically indicated in all phases of the care provision. The risk assessment is documented prior to transfer of care and/or transfer from the service. Risk assessments include a formal self-harm and suicide risk assessment and if dependent children are involved, the child harm risk assessment. The violence and aggression risk assessment is completed when indicated and particularly when there has been a prior history of harm to others. Vulnerability (risk to the consumer) would also be considered an important element of the risk assessment.
- All assessments are recorded using the formal CIMHA protocols.
- Assessments of indigenous people will include the provision of culturally appropriate services. In the event a consumer identifies as indigenous, a referral will be made directly to the indigenous mental health team/worker, to provide or participate in the initial assessment and ongoing service. A range of culturally appropriate services and strategies are available to support the safety and integration of culturally competent care across service settings.
- Assessments of alcohol and drug use are undertaken with every new consumer, and routinely throughout ongoing contact with the Mood ACU. Detection of alcohol and drug use problems is incorporated into the treatment plan.
- Physical healthcare assessments are routinely completed and documented. This is conducted by the medical officer or a health service provider external to the service (e.g. GP), but must be considered as part of the Mood ACU assessment. Documented evidence of the physical health assessment will be in the consumer clinical record (CIMHA). All efforts are made to ensure 100 per cent of all consumers have a nominated GP. Consumers are proactively supported to access primary healthcare for their health improvement. Potential physical health problems are identified and discussed with the GP and/or other primary healthcare providers. Where significant obstacles to accessing primary care exist, the Mood ACU will assist consumers to access the ED in the local public hospital to provide physical health services.
- The majority if not all mental health and other assessments are conducted in the community (if it is safe and suited to the consumers needs).
- The outcomes of assessments are communicated to the consumer, and should the consumer allow, to carers and other care providers, in an appropriate and timely manner. Communication will occur on the same day for crisis assessments.
For all other assessments, written or verbal communication will be conveyed in a timely manner.

- Information regarding consumers must be shared between relevant agencies based on the needs of the consumer, and provided in accordance with established information sharing protocols and legislation. Information sharing will occur in every case unless a significant barrier arises, such as inability to gain appropriate lawful consent.
- Family, carers and significant others will have their needs assessed and addressed as indicated and/or requested.
- Clinicians shall be aware of the policies and guidelines on protecting children and young people (0-18 years); this is particularly relevant for consumers with severe and persistent mental health disorders responsible for dependent children.
- Mood ACU clinicians do not engage in medicolegal reports (but can offer advice).
- Importantly, clinicians must report to the appropriate authorities when unlawful activities are identified, in consultation with their team leader and clinical consultant (e.g. reporting to the police, child safety services, etc).

### 2.1.4 Treatment

**Description**

Consumer-focused treatment has three primary goals:

1. relapse prevention and concordance to treatment
2. maximising the quality-of-life and adaptive functioning, and
3. promoting and maintaining recovery from the effects of the illness to the maximum extent possible.

Treatment is ‘evidence informed’ and ‘time-limited’.

There are three treatment intervention phases (Diagram 6), the application of one does not cancel out the others.

**Phase 1: Acute (focus on actions)**

This is the most resource intensive level of intervention. Mood ACU clinicians’ identify the initial diagnosis, prior to implementing the recovery and treatment plan. The setting chosen for treatment will depend primarily on safety issues and on the ability of the consumer to care for him or herself and adhere to treatment. Often multiple clinicians/service providers are involved in the diagnostic and care process.
Phase 2: Stabilisation (focus on integration)

The specialist mental health service and mainstream healthcare services jointly develop service and support plans with the consumer (and often their family). The aim of treatment is to develop a stable state of ‘functional’ recovery which will support the consumers transition to mainstream primary care and other services. Treatment interventions may not focus solely on symptom reduction, but on developing recovery skills (family psychoeducation, illness self management, social skills training, stress management, vocational support, trauma interventions, psychosocial interventions, diet, exercise, socialisation) and relapse prevention.

Phase 3: Stable (focus on strengths)

The goal here is to optimise the consumers functional recovery by successfully transitioning care to the mainstream healthcare and other support services. The support role of the specialist mental health service may include primary care consultation, community service training, and time limited crisis intervention.

Procedures
A. Medication treatment

General principles:

1. The consumer’s physical health is routinely monitored and reviewed.
2. Medication is more often than not, an essential component of the treatment plan.
3. Psychosocial interventions work synergistically with medication to optimise
treatment concordance and successful community living.

4. Medications are individualised because the consumer response is highly variable. Consideration is given to the consumer’s presenting complaint, their response to medication, including efficacy and side effects.

5. Consumers are involved in decisions and choices for medication. This includes being provided with information on the risks and benefits of both taking and not taking medication. However, because a high level of benefit is achieved with medication, consumer concordance is assertively sought.

6. Side effect profiles are created for each consumer, and the impact upon the consumers general health.

7. Medication dosages are maintained within the recommended range, and reasons for going outside the range are clearly justified and documented.

8. Regular and ongoing medication evaluations routinely occur: when the consumer responds to medication, when they do not respond to medication and when they develop side effects. Standardised measures are used for baseline and later assessments.

9. The consumers GP is regularly informed and supported to eventually manage the consumers care in the community.

B. Psychosocial treatments

General principles:

1. Optimal management requires the integration of medication and psychosocial interventions. These interventions are complementary approaches.

2. Effective psychosocial intervention may improve medication concordance, reduce the risk of relapse and the need for readmission to hospital, reduce distress resulting from the symptoms, improve functioning and quality of life, provide support for consumers their families and carers.

3. Common comorbid conditions such as substance misuse/abuse, are identified and addressed with psychosocial interventions.

4. Listening and attending to the consumer’s concerns is more likely to develop empathy, rapport, and a good therapeutic relationship. As well, listening can improve engagement and concordance to treatment.

5. Consumers, carers and their families are offered illness education, as well as ways to reduce the risk of relapse. It is important to provide a realistic hopeful view of the future. Doctors are involved in psychoeducation.
6. The consumer, carers, families and clinicians develop shared, realistic goals for treatment and recovery (progress toward these goals is monitored and evaluated).

7. Specialist and mainstream service providers share plans for early recognition of relapse and crisis response with the consumer, carer and family.

8. Consumers have access to evidence based programs that develop skills for daily living, meeting vocational and educational goals, managing finances, developing and maintaining social relationships, physical healthcare, socialisation, diet, exercise and coping with the impact of symptoms.

9. It goes without saying that staff providing psychosocial interventions are appropriately trained and skilled in the delivery of these interventions. Evidence based interventions work best when delivered by skilled clinicians.

10. Refugee and migrant populations, consumers who are homeless or at risk of homelessness, consumers with alcohol and drug misuse and consumers with pre-existing disabilities, and Aboriginal and Torres Strait Islanders - services provided to these consumer groups are culturally-appropriate and include collaboration with service integration coordinators who are required to arrange necessary support and assistance from other government and non-government agencies.

11. The consumer’s GP is informed of the interventions provided.

12. Clinicians may suggest the following useful psychosocial interventions when formulating the consumers recovery plan:

- medication concordance and psychoeducation training
- integrated case management (proactively partnering with all service providers)
- vocational interventions (supporting return to work or education)
- skills training (stress management, problem solving, illness self management, social skills training)
- motivational interviewing (MI)
- trauma therapy (CBT for PTSD)
- group therapy
- interpersonal therapy (IPT)
- mindfulness based cognitive therapy (MBCT)
- schema focused therapy
- acceptance and commitment therapy (ACT)
- cognitive-behavioural therapy (CBT)
- family therapy and family interventions (narrative therapy)
- cognitive remediation
- peer support, self-help and recovery
✅ healthy lifestyle interventions (exercise, peer support)
✅ integrated treatments for coexisting disorders (substance abuse and trauma therapy, physical health management and eating disorder)
✅ dialectical behaviour therapy.

2.1.5 Recovery planning

Description
Recovery plans are developed with the consumer and document the key actions to be undertaken. It is developed on the premise that consumers can and do recover from their illness.

Procedures
✅ Every effort will be made to ensure that treatment care planning (recovery) focuses on the consumer’s own goals.
✅ An individual recovery plan is developed with all consumers who are opened to the service (coordinated by the Principal Service Provider (PSP)).
✅ Review of the consumer’s progress and planning of future goals is integrated into the recovery plan.
✅ Recovery and relapse prevention planning is discussed in partnership with every consumer.
✅ Where conflicting goals exist (e.g. for consumers receiving involuntary treatment), they will be clearly outlined and addressed in a way that is most consistent with the consumer’s goals and values.
✅ Consumers are strongly encouraged to have ownership of their recovery plan.

2.1.6 Continuity-of-care

Description
Clinical pathways are articulated and concise information is provided to consumers, families, carers and referral sources to ensure continuity-of-care exists across a 24 hour, 7 day period.

Procedures
✅ Where possible, the clinician who conducted the initial assessment becomes the case manager (principal service provider).
✅ The case manager (principal service provider) is responsible for coordinating appropriate assessment, care and review, and completing referral and ongoing care processes.
✅ The process undertaken for sharing information, between service providers and services, is explicitly documented by the principal service provider.
Relevant clinical information provided or accessible will include service response information. Provision of this information is documented in the clinical record, including the recovery plan.

The consumer’s treating unit is identified in the clinical record (CIMHA).

If ongoing care is not required after the initial assessment (screening), the clinician who conducted the screening assessment will be responsible for effectively managing all associated communication (with the stakeholders and case review team). Documentation processes are to be completed within 24 hours. If referral to another clinical service is required, a follow-up communication by the clinician is required to ensure linkage is successful.

2.1.7 External transfer-of-care

Description

External transfer-of-care (outside MSAMHS) incorporates:

- information sharing
- relapse prevention procedures
- crisis management procedures
- clearly articulated service re-entry procedures.

Procedures

✓ Comprehensive liaison and handover occurs where appropriate with all other service providers who are or will contribute to the consumer’s ongoing care.
✓ Ongoing service providers are involved in transfer-of-care planning.
✓ Consumers are encouraged to actively contribute to and to countersign their transfer plan.
✓ Clinicians are responsible for ensuring letters are sent to key health service providers (e.g. GP) on the transfer day.
✓ Exit/service closure letters need to be comprehensive and indicate diagnosis, treatment provided, progress of care, recommendations for ongoing care and procedures for re-referral.
✓ Relapse patterns, risk assessment and risk management information is provided to consumers, family and carers as clinically indicated.
✓ A follow-up direct contact with ongoing key health service providers (e.g. GP) will occur to ensure the transfer information was received and the service provider agrees to the provision of ongoing care.
✓ Where possible, family/carers will also be directly involved in transfer planning.
✓ Where consumers are lost to follow up, there will be documented evidence of attempts to contact the consumer, family/carers and other service providers before the case record is closed to the Mood ACU.
2.1.8 Internal transfer-of-care

Description
Disengagement by the Mood ACU does not occur before the receiving ACU has made contact with the consumer and scheduled a first appointment.

Procedures
- Internal transfers require senior doctor to doctor approval.
- Policy and procedure guidelines for internal transfers are followed, and receiving ACUs make strenuous efforts to establish contact within a reasonable time period for all involved.
- The time period for the consumer being contacted is individually determined at the local level between the Mood ACU and the receiving service/s.
- A verbal handover is provided on every transfer occasion.
- A timely written handover is provided on every transfer occasion.
- CIMHA documentation supports the transfer-of-care and records the communications undertaken.
- Consumers and their family/carers are informed of transfer procedures.

2.1.9 Partnerships

Description
Strong private partnerships are initiated and maintained with local healthcare, government and non-government services.

Procedures
- Peer support worker services are engaged.
- Clinicians work in close collaboration with other health related service providers to meet the individual consumer’s (and often family and carer) needs.
- Assistance is offered to local government and non-government agencies to assist with the consumer’s recovery and social inclusion (e.g. return to work programs, vocational training, further education and training, housing, debt management, diet, exercise, socialisation, etc).
- Advice, education and support is provided to other service providers (with the consumers consent).
- Advice and strategies are provided to shared-care workers on how to identify and manage the consumers symptoms (e.g. supporting the consumers GP with a relapse prevention program).
- When more than one service provider is involved in service delivery, the principal service provider / clinician will initiate and participate in discussions around which service will adopt the role of lead agency.
The mental health service integration coordinators (SIC) are engaged to work collaboratively with the clinician to engage other government agencies in the provision of required services.

When consumers have specific needs (e.g. sensory impairment, cultural, addictions) to ensure effective communication, the clinician engages the assistance of the appropriate services. Certain population groups require specific consideration and collaborative support. This includes people from Culturally and Linguistically Diverse (CALD) backgrounds and Aboriginal and Torres Strait Islander people.

A strong partnership will be initiated and maintained with other government agencies including Centerlink, Housing, Police, Ambulance and Medicare services. With the consumers permission, clinicians shall advocate:

- joint private planning and decision making
- shared care (with GPs, other mental health providers, NGOs, ATAP providers, etc)
- utilising an exchange of knowledge and expertise
- effective communication.

2.1.10 Working with carers/families

Description

Family/carers/significant others are involved in the consumers recovery as much as possible. Significant effort is made to support this involvement.

Procedures

- The consumer’s and/or guardian’s consent to disclose information and to involve family/carers in the recovery plan, is sought in every case (and documented on CIMHA).
- Information sharing, with family and carers, occurs for every case unless a significant barrier arises, such as inability to gain appropriate lawful consent.
- When applicable, family and carer informed consent is sought concerning their involvement.
- The needs of families, carers and significant others is routinely addressed by the principal service provider.
- Children of parents with a mental illness are routinely considered as part of all assessments and interventions.
- All consumers are offered information and assistance to access local peer and other support services. Peer support services may be provided by internal or external providers.
2.1.11 Team approach

Description
The treating multidisciplinary team, is accountable and shares the responsibility for the care of the consumer with the principal service provider.

Procedures
- The assessment and treatment services are delivered in consultation/discussion with the multidisciplinary team. The principal service provider acts in the role of case manager, coordinating and delivering services as recommended and supported by the Mood ACU treating team.
- The consumer and family/carers are informed of the multidisciplinary team approach to care.
- Clear clinical, operational and professional leadership is provided within the multidisciplinary team.
- Case coordination is managed to ensure effective use of resources and to support staff to respond to each presentation in a timely, effective manner.
- Discipline specific skills and knowledge is utilised as appropriate in all aspects of service provision (medical, psychological, social work, occupational therapy).

2.1.12 Case review

Description
Clinical cases are routinely discussed at the clinical review meetings, which are held weekly. All clinicians attend the case review meetings, chaired by the consultant psychiatrist/clinical leader.

Procedures
- First presentations, ongoing assessments, treatment and recovery plans, and significant changes in the consumer’s healthcare status are regularly and routinely discussed at the multidisciplinary team case reviews.
- All case review discussions are documented in the CIMHA record. Details of the initial case review will include the consumer care summary (documented are clinical issues raised, assessment and treatment care plan, and those responsible for actions).
- Changes in treatment throughout the course of care are discussed by the team and actions are agreed to and assigned to specific clinicians and recorded in the clinical record (initial care review summary).
- Ad-hoc case reviews occur to address complex clinical issues and following a critical event.
A consultant psychiatrist is in attendance at case reviews. A case review will provide an in-depth review and follow a set agenda. All clinical discussion and notes from the review are recorded in the clinical file and the consumer care review summary.

Critical events are reviewed utilising the clinical incident management implementation standard.

Consumers with ‘high risk’ crisis presentations and unstable healthcare status are monitored and discussed daily by the case review team.

Consumers who are stable, not high risk and have a clear treatment and recovery plan are discussed within 90 days.

Changes to the treatment intervention plan is completed in collaboration with the consumer (changes and recommendations may arise from the case review process, but should be implemented with the consumers cooperation).

Every consumer’s progress and their outcome measures are regularly monitored (clinicians routinely complete and collect the outcome measures information).

Structured risk and review processes are utilised as appropriate (self-harm and suicide risk assessment).

2.1.13 CIMHA

Description

Clinicians enter and review all required information into the Consumer Integrated Mental Health Application (CIMHA) in accordance with the approved statewide and district business rules.

Procedures

Clinicians must enter:

- **all** 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 information
- **all** provisions of service contacts
- **all** outcomes collection occasions
- **all** clinical Notes for the forms that comprise the statewide standardised suite of clinical documentation for mental health
- **all Mental Health Act 2000** information.

You must also regularly review and update:

- any data warning and data discrepancies
- demographic details including the current living address and phone numbers
- external contacts including the preferred contact, Allied Person and GP details
- alerts
☑ internal contacts
☑ diagnosis
☑ recovery plans/care plans/treatment plans
☑ the involuntary patient summary (IPS) and photo (where required)
☑ progress notes consecutively within the clinical record according to date
☑ the routine outcome measure mandated through the National Outcomes and Case Mix Collection (NOCC) as part of the assessment, recovery planning and service development. The outcome measures are discussed on entry and exit from the Mood ACU. Results of routine outcome data is discussed with consumers
☑ clinical records to ensure they are kept in accordance with legislative requirements.
3.0 Introduction

Where Part 2 focused on those activities related to the consumers care, Part 3 describes the core elements associated with the system-of-care. There is obvious cross over between Parts 2 and 3, however the essence of Part 3 is its relevance to operational outcomes.

3.1 Service hours

- While some variation may occur, routine assessments and interventions are generally scheduled between the hours 8.30am and 4.30pm (Monday to Friday).
- Outside normal business hours services are provided by the RAS ACU (MH CALL, Acute Care Team, Hospital Emergency Department).

3.2 Multidisciplinary workforce

The Mood ACU workforce is based on:

- A multidisciplinary staffing profile that incorporates the skills of nursing, psychology, occupational therapy, social work, peer support workers and medical officers (psychiatry). The proportion of disciplines may be locally determined, within the guidelines of relevant policy and funding restrictions.
- A consultant psychiatrist is accessible for urgent consultation 24 hours, 7 days a week (outside of business hours the oncall consultant is the point of access).
- Clinical staff deliver both specialist discipline-specific assessments and interventions, in addition to a range of generic case management duties.
- Permanent clinicians are appointed, or working towards becoming authorised mental health practitioners.
- Administrative support is provided to local teams.
3.3 Roles and responsibility

**Team leader**

- service and operational leadership (operationalising strategic priorities)
- service leadership, service development and management
- service integration and partnership development with key stakeholders
- performance review of non-medical staff
- analysis and reporting on clinician and service activity for team
- organisational and team culture
- operational management of the clinical day to day functioning of the team
- delegation of daily clinical responsibilities within the team
- responsible for collecting and reporting key performance information.

**Consultant psychiatrist/registrars**

- medical leadership and clinical direction
- lead best practice program and service delivery
- direct and supervise the medical management of consumers
- provision of the medical services
- direct clinical assessment and treatment/intervention
- lead case reviews
- lead clinical integration with other relevant clinical specialities
- lead education and up-skilling of clinical team members
- completion of service activity data (CIMHA records).

**Clinical staff**

- integrated case management (guided by Mood ACU framework)
- direct clinical assessment and service delivery
- meet case review expectations and standards
- lead consumer and carer advocacy, participation and involvement
- completion of outcomes and service activity data (CIMHA records)
- attend inservice education, supervision and performance reviews.
Discipline-specific roles

☑ Discipline specific skills are utilised to ensure comprehensive assessments of consumers occur. Profession specific skills are also used when determining and undertaking a particular type of intervention, level of service or the most appropriate member of the team to case manage a consumer.
☑ The multidisciplinary team is supported by administrative officers who assist clinicians with the day-to-day operations of the Mood ACU.

Additional role specifications

☑ Clinicians enter ‘all’ consumer information into CIMHA.
☑ Clinicians hold a current Queensland Drivers licence.
☑ Clinicians hold a current registration with their respective professional bodies or credentialing requirements.
☑ Clinicians are authorised mental health practitioners under the Mental Health Act 2000, or eligible for authorisation.
☑ Clinicains embrace safety, quality improvement and goal directed change.
☑ Clinicians are required to engage in formal professional supervision on a monthly basis.
☑ Clinicians have a current professional appraisal development.
☑ Clinicians attend and present at regular in-service programs.
☑ Clinicians submit all leave requests to the team leader.
☑ Clinicians attend mandatory annual training in fire, aggressive behaviour management, infection control and basic life support.
☑ Clinicians are familiar with the policies and work unit guidelines available on the local QHEPS and MEDSPEN intranet sites.

3.4 Leadership

Leadership is the ability to provide direction and cope with change. It involves implementing a service vision, developing strategies for producing the changes needed to realise the vision, and aligning staff and motivating and inspiring staff to overcome obstacles in pursuit of the vision.

Leadership within the Mood ACU is based on staff capability rather than profession; there is healthy debate and collaboration rather than interdisciplinary conflict and a focus on team rather than on the individual professions. The team is stronger and more effective when the capability of its members rather than one or two professions dominate proceedings.
Key tasks include:

☑ ensuring principle-led and value-based work practices are clearly evident
☑ creating a method that encourages and supports staff to contribute to making the work practices happen (in pursuit of the vision)
☑ sponsoring regular information and communication meetings, structured orientation, training and education programs
☑ ensuring the right people are doing the right work; without duplication of services
☑ articulating that intentional breaches of relevant policies and procedures are not tolerated
☑ ensuring adverse events are disclosed and investigated and lessons are learned and applied
☑ influencing how, when, where and what work practices occur through their statements, actions, staff supervision and responses to circumstances and events
☑ supporting and encouraging staff to provide quality care; the expectation is that staff will work within an agreed scope of clinical practice, congruent with the MSAMHS Strategic Plan 2014-2017
☑ implementing policies, procedures, role descriptions and associated documentation to create a clear framework to allow each staff member to understand their roles and responsibilities and the expectations that apply regarding service outcomes, safety and quality
☑ being responsible for conveying consistent work practice and work place expectations (staff know what to do, when, why, how and where)
☑ ensuring performance appraisals and supervision activities are current.

3.5 Consumer engagement

Engagement is a systematic ongoing process that actively engages the consumer in their own care and treatment, and where appropriate, encourages the participation of carers.

Engagement ensures consumers and their carers are:

☑ aware of their rights and responsibilities
☑ informed about their treatment and healthcare
☑ actively involved in decision-making processes
☑ certain their information is treated in accordance with the legislative requirements covering consent, privacy and confidentiality.
The purpose of engaging consumers and carers is:
- to encourage and obtain consumer (family and carer if appropriate) participation in their care and treatment
- to support healthy relationships between the consumers and their family and carers.

The range of key activities in relation to consumer engagement include:
- informing and collaborating with consumers about the process of assessment and care coordination
- providing access to support services (e.g. interpreter services), materials and information promoting culturally sensitive practice
- with the consumer developing and implementing assessment and care plans.

### 3.6 Sector engagement

Sector engagement is a crucial component of the specialist mental health service program. Sector engagement is an ongoing assertive process that initiates the process of shared care or the transfer-of-care to the mainstream healthcare services. As such, sector engagement aims to:

- build and maintain service pathways, networks and effective working relationships to enhance access and entry to the right services
- establish common consumer (carer and family) and service goals
- determine and develop agreed methods of shared communication and service coordination
- conjointly identify, manage and resolve service difficulties and conflicts and achieve positive consumer outcomes
- gather, convey and receive service information, knowledge and ideas
- collaborate on policy and future program development.

Sector engagement is about promoting ‘continuity-of-care’ (whereby the consumer experiences a seamless system-of-care).

**Key internal (MSAMHS) relationships include:**
- 1300 MH CALL
- Acute Care Team (ACT)
- acute inpatient units
- other ACUs
- service integration coordinators and peer support workers
- homeless health outreach teams
- primary care coordinators
✓ transitional housing
✓ Indigenous mental health services
✓ forensic mental health services
✓ police mental health liaison officer.

**Key external (specialist and mainstream healthcare) relationships include:**

✓ hospital ED (Princess Alexandra, Logan, Redlands, Beaudesert)
✓ emergency services (e.g. Queensland Health, Queensland Police Service, Queensland Ambulance Service)
✓ primary care providers (e.g. GPs, community health services, Medicare Locals/private practitioners (ATAPS))
✓ government and non-government organisations (e.g. Centerlink, Anglicare, Lifeline, Relationships Australia) and other community support services (e.g. peer support programs)
✓ vocational and educational services
✓ faith-based and cultural services.

### 3.7 Clinical documentation

There is no ‘single source of truth’ - clinicians should be aware that there is always likely to be other consumer clinical records that contribute to the overall clinical record.

Clinicians should also be aware that electronically signed clinical notes information entered in CIMHA is the legal version of the note and the unannotated printed versions are copies only.

The availability of any source of information about a consumer does not obviate the requirement for comprehensive clinical history taking and the need for clinicians to access a wide range of information sources about the consumers under their treatment or care.

**Accuracy**

To be an accurate clinical record, documentation should include:

✓ clinically-relevant interactions
✓ clinical event (what occurred, when, why, how managed, who involved)
✓ history of event (e.g. assessment and treatment interventions etc)
✓ changes in behaviour or healthcare status
✓ adverse events (e.g. self harm, suicide attempts, violence)
✓ direct reporting (e.g. verbatim consumer questions, statements and information provided as it happened)
✓ indirect reporting (e.g. heresay reported as such).
The clinician who is directly involved with the consumer/carer or who witnessed the event or has direct knowledge concerning the case record writes the clinical report and case records (case records are not written on behalf of a colleague based on handover information).

Accuracy is further enhanced when case records are completed immediately after the event (e.g. mental state examination). Records that are written hours later or the next morning are likely to have their accuracy questioned.

The time and date of each entry should be noted in the record next to the entry (the time and date of the event should be recorded separately). For example, in the event where notes are written at a later time it is preferable to record the date and time that the notes were made while making it clear in the notes the time of the event being written about.

**Objectivity**

When writing in clinical records, avoid making subjective statements about the consumer or their circumstances, it is better to document observations rather than subjective assessments.

Clinical opinion, recorded as ‘opinion’, should be supported by the recording of objective data that gave rise to that opinion.

A clinical record should always be written using the language of the professional, without negativity and without criticism of others. Sometime in the future the consumer (or their carer) may read your clinical note. Always write with the potential reader in mind.

**Legibility**

Documentation is of little value if handwriting cannot be understood by other clinicians. Misinterpretation of handwriting can lead to significant error in care.

Abbreviations should be avoided unless they are widely used and known in the health industry (Queensland Health has an abbreviations policy and list of acceptable abbreviations and clinicians are to make themselves aware of this policy).

**Formatting details**

Each entry should:

- be written in consumer focused or person-centred language
- be written in black ball-point pen (not ink or pencil)
- include the date and time (in 24 hour clock) usually in the left hand margin
- be signed with your name and designation (e.g. RN, RMO, Psychologist) clearly printed below the signature.

**Making amendments**

If an amendment must be made it is preferable to:
put a neat line through the entry (the original entry must remain legible) and add a note in the margin stating why the amendment has been made and initial the change

add the correct entry and sign

never delete material by scratching it out, covering with correction fluid or typing over it

all clinicians must ensure that they are documenting to a standard that will ensure the best outcome for their mental health care program and for medico legal accuracy, but above all, for the continuing optimum care of their consumers.

3.8 Clinical governance

The following outlines a broad clinical governance structure for the Mood ACU:

Staff structure

The Mood ACU is comprised of multidisciplinary teams located in the local Princess Alexandra, Redland and Logan/Browns Plains catchment community settings.

Local teams have a designated team leader and consultant psychiatrist to provide governance within their delegation. Key duties include:

- Clear clinical, operational and professional leadership is established and communicated to all internal and external stakeholders.
- Within the team, the team leader will provide operational governance.
- The consultant psychiatrist will provide and be responsible for clinical governance.
- These position holders will establish a strong collaborative working relationship.

Service components

- specialist pharmacological and psychosocial treatments
- integrated case management
- outreach service provision
- in-reach to acute inpatient services.

Service linkages

The Mood ACU has established service pathways with specialist mental health programs and services including addictive services, CALD and Aboriginal and Torres Strait Islander.

The Mood ACU operates with established service pathways to local primary care services and government and non-government services, community based programs (peer support services) and networks.
Support components
The Mood ACU is supported by:

- assessment and management processes (e.g. statewide suite of clinical forms) that meet best practice and service requirements
- established referral systems between and within other relevant services and programs
- clinical handover systems, monitoring and reviewing processes that promote multidisciplinary collaboration and team decision-making both within the team and across the mental health service.

Staff Support
Staff are supported by:

- appropriate models of clinical supervision
- discipline-specific training and education, professional development, peer review and supervision
- staff credentialing processes
- education and training sessions.

Quality program
Quality processes include:

- multidisciplinary clinical review and audit programs
- periodic and ongoing outcome analysis
- review of all adverse events and critical incidents
- consumer and staff surveys
- staff evaluation and performance appraisals
- staff development and training opportunities
- budget reviews
- development and review of procedures and work instructions
- processes for identifying and managing risks that link to the mental health service risk management plan
- staff safety procedures that cover clinical emergencies, working in isolation, home visits, critical incident management, infection control procedures and other relevant matters.

Records management
Record management systems that support governance include:

- informed consent and consumer rights systems in accordance with the relevant legislation
- clinical documentation processes, policies and procedures
3.9 Clinician case load

The size of a clinician’s case load takes into consideration a range of factors, including:
- complexity of the consumers need
- diagnosis
- local population and demography
- size of the particular Mood ACU team
- skills and experience of the particular clinician
- capacity for clinical supervision and support
- the needs and function of other mental health teams in the district.

In the event individual case loads exceed the capacity to provide optimal care, a review of all factors that influence case load is conducted by the clinical and operational leaders.

3.10 Clinician supervision

Supervision is the most appropriate learning medium for the clinician because it is a ‘learning by doing’ process rather than a distant, classroom type of experience. Supervision provides clinicians with a facilitated, ongoing reflection of their skills and areas of clinical strengths and weaknesses.

In line with clinical governance, it is essential that there is a well-defined and robust system of clinical supervision within the Mood ACU.

The purpose of supervision is to support professional development, while ensuring skills and competencies meet the needs of consumers.

The range of key supervision activities include:
- completing regular supervision sessions
- identifying learning and training objectives
- resolution of conflict (arbitrator identified)
- identifying roles and responsibilities
specifying workplace practicalities e.g. supervision location, supervision practices, etc
identifying boundaries e.g. time and agreed supervision agenda
Identifying the documentation to be used
specifying confidentiality (adherence to a professional code of conduct and Queensland Health policy)
specifying key actions in the event of non-attendance or cancellation
identifying frequency & duration of the supervision sessions.

Resources that support supervision include:
- the supervision contract
- the supervision record.

The expected supervision outcomes are:
- At the start of employment the supervision process is made clear to all new staff members.
- Supervision is included in the role description.
- Emergency adhoc supervision is available in times of crisis.
- Clinical supervision occurs at a minimum of once every two weeks or more frequently as per professional body guidance.
- The Team Leader has a clear system of monitoring and auditing supervision. This is to be reviewed every six months.
- The Mood ACU has clear clinical supervision guidelines which incorporate supervision contracts between the supervisor and supervisee.
- Supervision adheres to a specific structure (relevant to the appropriate professional body) and also addresses both clinical and managerial factors.
- Supervisors receive/have the appropriate training.

Good supervision occurs when:
- supervision reviews key consumer and carer outcomes (e.g. satisfaction)
- supervision monitors the quality of the supervisees work practices across the continuum-of-services and supports
- the quality of the supervision sessions are regularly monitored and reviewed
- supervision develops the core skills and training needs for the supervisee
- supervision guides self-development
- supervision supports the supervisee in stressful situations.
3.11 Clinician training

Staff are provided with continuing education opportunities, mandatory training, clinical supervision and other support mechanisms to support their learning and clinical capabilities.

Access to education and training includes (but will not be limited to):

- CIMHA (including clinical forms training)
- mental health assessment
- clinical risk assessment
- de-escalation training.
- aggression behaviour management
- Mental Health Act 2000.
- alcohol and drug assessment and interventions
- clinical and operational skills/knowledge development (including mental health generic and discipline-specific training needs)
- medication and side effect management
- consumer focused care planning
- routine outcome measurement training
- cultural capability training.
Appendix 1: Assessment measures

Introduction

The information provided establishes the assessment essentials clinicians are advised to follow. This information brings together evidence from a range of sources, including academic literature and research, current service practices and proposals, and people’s own experiences to address the service expectations identified in the National Standards for Mental Health Services (2010).

The aim is to improve service outcomes and to deliver services in a more individualised way, more efficiently. This is true of clinicians’ where they seek to improve the way their services work so that more personalised, evidenced-based and effective service is delivered in a more cost effective way.

Getting started

The crucial first step is to explain to the consumer the purpose of the assessment, bearing in mind the consumer would already have undergone a full mental health assessment.

This assessment will supplement the information gathered and documented already; it should not replicate current information reported in the clinical file, unless it is to further clarify an event, circumstance or issue.

The aim of this first step is to identify the consumer’s needs and concerns, and to prioritise what is to happen next.

The consumer is informed that certain measures are to be used to help construct the treatment and recovery plan (the clinician may complete these with the consumer at this time, or alternatively the consumer completes them in their own time and they are collected during the next session). The primary goal of assessment is to clarify the consumer’s needs and concerns, to prioritise these and to develop a practical action plan. Clinicians tailor their assessment to obtain the information sought. Obviously, if clinical information is absent from the clinical record – then the clinician completes a full mental health assessment (using the routine CIMHA forms).
In most cases, the assessments are completed in approximately 40-60 minutes.

Collection protocol

This collection protocol guides the Mood ACU clinicians to collect the relevant outcomes information, including the standard information currently collected on the consumer (National Outcome Casemix Collection (NOCC) on CIMHA).

The outcome measures identified and this protocol represent a deliberate emphasis on the collection of quality clinical information. It recognises the need for compliance, as clinicians direct their efforts toward the collection of measures information that will inform consumer treatment planning and decision-making.

This collection protocol is for all Mood ACU clinicians. The purpose of the collections (outside the scope of the standard mental health outcomes collection) is to:

- deliver to the clinician and consumer time dependent comparative information (pre, during and post treatment intervention) in order to provide an understanding of change in the consumer’s health status
- deliver case complexity information to guide case planning
- provide treatment information required by the Activity Based Funding (ABF) program.

Collection occasions

A collection occasion is defined as an occasion when the outcome measures and the case complexity information are collected in accordance with the collection protocol. There are three collection occasions:

1. Beginning-of-care collection: marks the commencement of the treatment service episode. This collection denotes the complete collection.
2. Mid collection: occurs every 90 days and repeats the previous collection.
3. End-of-care collection: occurs when the treatment service episode is closed.

The specific collections occur for all adult consumers, irrespective of the service delivery provided.

Collection methods

The following tables summarise the measures and clinical information to be collected. In general, the measures and clinical information collected will be used for the purposes of guiding the development of the treatment plan, as well as outcome evaluation and case complexity. Measurement of outcomes requires information to be collected from the beginning-of-care and end-of-care collections to allow for an assessment of change overtime.
### Essential measures (completed for all consumers)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Inventory (MHI)</td>
<td>Consumer measure</td>
</tr>
<tr>
<td>Health of the Nation Outcomes Scale (HONOS)</td>
<td>Clinician measure</td>
</tr>
<tr>
<td>Life Skills Profile - 16 (LPS16)</td>
<td>Consumer measure</td>
</tr>
<tr>
<td>Clinical Global Impression (CGI)</td>
<td>Clinician measure</td>
</tr>
<tr>
<td>Kessler 10 (+ 4)</td>
<td>Consumer measure</td>
</tr>
<tr>
<td>Ideopathic Measure - SUDS</td>
<td>Consumer measure</td>
</tr>
<tr>
<td>Short Form 12 Health Survey (SF12)</td>
<td>Consumer measure</td>
</tr>
</tbody>
</table>

### Preferred comorbidities measures (completed for most consumers)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Psychiatric Rating Scale (BPRS)</td>
<td>Clinician measure</td>
</tr>
<tr>
<td>Alcohol Use Disorders Identification Test (AUDIT 6)</td>
<td>Clinician measure</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder Checklist (PCL-C)</td>
<td>Clinician measure</td>
</tr>
<tr>
<td>Social and Occupational Functioning Assessment Scale (SOFAS)</td>
<td>Clinician measure</td>
</tr>
<tr>
<td>Clinical Global Impression - Bipolar</td>
<td>Clinician measure</td>
</tr>
</tbody>
</table>

Essential measures are collected from all consumers, while preferred measures are collected from those consumers who have or may have comorbid conditions. All collections are summarised and reported on CIMHA and to the case review team.