Mental Health Case Management Policy

1. Background

Case management (CM) is a key mechanism to provide collaborative care in partnership with consumers, family members and carers. CM enables care to be coordinated, tailored to the individual and is the primary method for achieving continuity of care in a timely and effective manner. WA Country Health Service (WACHS) supports the goal of CM; to promote recovery and improve the health and functioning of consumers accessing WACHS Mental Health (MH) Services.

2. Policy Statement

All consumers will be allocated a Case Manager from entrance to exit from WACHS MH Services. This policy details the key principles of effective CM and describes the roles and responsibilities of performing CM within WACHS MH Services.

2.1 Key Principles

- To enable effective partnerships, WACHS MH Services services will provide information to consumers about CM in the format and language most suited to the consumer.
- With consideration that CM is most effective when the consumer's family, carers and/or significant others are involved in their care, WACHS respects the rights of the consumer to choose to involve others in their care, in accordance with the Charter of Mental Health Care Principles 2014 and the *Mental Health Act (MHA) 2014.*
- WACHS MH recognises that CM must be age, developmentally and culturally appropriate and relevant to the circumstances of consumers and carers
- For Aboriginal consumers, involvement of an Aboriginal MH Worker will occur wherever possible, in all aspects of CM, including in the development of the management plan
- Wherever possible, the right of the consumer to access a clinician of their own gender will be met[1]
- A Case Manager will be allocated after initial referral/entry and determination of needs (via a process of Triage, Choice Appointment or similar assessment of needs). Best practice is to allocate a Case Manager based on a positive answer to either of two questions: is the MH service providing *treatment* to the referred person OR would the consumer consider they are now a patient of the MH service?
- CM continues across periods of inpatient MH care, unless such admission extends beyond a three month period with uncertainty of the consumer returning to the service
- Where possible and if appropriate, consumers who re-enter a MH service will be allocated to their previous case manager.

[1] National Standards for Mental Health Services Standard 1:17

3. Definitions

Care Transfer Summary	Part of the Statewide Standardised Clinical Documentation (SSCD) suite of forms, used for the handover for MH consumers at the completion or transfer of care from a MH service.
Case Management	Case Management is a process to meet a consumer's needs and promote recovery by placing the responsibility of coordinating assessment, care planning and delivery, as well as the brokering of additional support and specialist health services with one individual mental health professional. The Case Manager works within a multidisciplinary team and in collaboration with the consumer, family members, personal and professional carers, and undertakes regular communication with all people involved.
Case Manager	Any member of the multidisciplinary team who: • Is competent in delivering mental health care with a clinical skill set required to deliver the identified therapeutic and recovery focussed goals • Has a good understanding of mental disorders and their management • Is able to develop and maintain collaborative partnerships, including therapeutic relationships, with consumers, family members, carers and significant others • Has current registration with an appropriate professional body and has personal indemnity insurance
Crisis Plan	A specific form of care plan, available on the Psychiatric Services On Line Information System (PSOLIS) that details the relevant background, goals and specific actions in response to a crisis in the consumer's recovery journey.
Management Plan/Care Plan/Recovery Management Plan/Treatment Support and Discharge Plan	Terms used to describe the written form that details the relevant background, goals and actions determined in the process of planning care. For the purposes of this document, the term 'Management Plan' will be used to describe this function.
Responsible Practitioner	Legal term for a specified clinician who, with the Supervising Psychiatrist, ensures all legal obligations are met with respect to Community Treatment Orders

4. Roles and Responsibilities

4.1 Case Manager roles and responsibilities: General

The Case Manager is to:

- Partner with consumers and their carers to plan, document and implement an individual recovery-oriented management plan, which identifies the goals of care and ensure that it is reviewed, (inclusive of senior medical oversight), at a minimum of every three months
- Plan, provide and oversee the delivery of care set out in the management plan and ensure that it is adhered to by those responsible for delivering care
- Ensure, through appropriate risk assessment, that a PSOLIS Crisis Plan is completed when required
- Conduct mandatory National Outcomes and Casemix Collection (NOCC) measures and record changes in phase of care, as well as other recovery-oriented measures of progress at the minimum of every three months
- Ensure regular communication is undertaken with the General Practitioner (GP), particularly with respect to physical health care, determining and planning any shared care needs and in preparing for discharge and transfer of care
- Ensure consumers, carers/significant others and the GP are informed of re-entry options and processes
- Ensure discharge planning, with senior medical staff oversight, commences with the consumer, their carer (if appropriate) and the multi-disciplinary team, at the time of activation into the health service
- Ensure all documentation complies with relevant regulation, legislation and overarching policy in alignment with the SSCD framework.

4.2 Case Manager roles and responsibilities: The management plan

The case manager is to partner with consumers and their carers to plan, document and implement an individual recovery-oriented management plan. When developing the management plan, the case manager will:

- Facilitate where possible the consumer to direct the planning process, using their own language, and sharing it with others of their choice
- Assign responsibility for each action (including the case manager, consumer, carers, peers and/or other services or practitioners)
- Consider the safety of the consumer and others to determine appropriate care planning
- Consider any regionally endorsed recovery focussed processes
- Invite the consumer to sign their management plan, as evidence that they agree with and support the treatment goals. Where a consumer declines to sign their plan this is to be documented in the medical record
- Invite the consumer's carer to participate in the development of the plan and to countersign it

- With the consumer's consent, invite other involved parties such as Non-Government Organisations (NGOs) supporting the consumer, to contribute to the development of the plan
- Provide a copy of the plan to the consumer and their carer and to any other involved parties on request / agreement of the consumer
- Enter or transcribe the plan onto PSOLIS, and file a printed copy in the consumer's medical record.

Where a consumer declines to participate in the development of a management plan, the case manager will develop the plan, reflecting in so far as possible, the known goals of the consumer, and involving the carer where appropriate.

4.3 WACHS MH Service roles and responsibilities: Community based involuntary treatment orders

For consumers subject to a community based involuntary treatment order (Community Treatment Order – Form 5A, CTO):

- The case manager may also be the responsible practitioner. If so, the case manager will ensure that the legal obligations of the CTO are met, in conjunction with the psychiatrist supervising the CTO
- The treating psychiatrist has accountability to ensure a current management plan is recorded on PSOLIS and printed and placed in the person's medical record.

4.4 WACHS MH Service roles and responsibilities: Admission to an Acute Psychiatric Unit.

For consumers admitted to a WACHS MH Acute Psychiatric Unit (inpatient):

- CM continues unless such admission extends beyond a three month period with uncertainty of the consumer returning to the service
- CM will be allocated to an inpatient team which provides hospital based treatment. The inpatient team will allocate a nurse for each shift who will be responsible for consumer, family and carer engagement and for co-ordinating care for the duration of the shift
- If the consumer does not have a community case manager, the inpatient team will determine this need as soon as possible, and if required, ensure the consumer is referred for community CM, or linked with other community supports as relevant.
- If the consumer has a community MH case manager, that person will liaise with the inpatient team/allocated nurse to ensure that the consumer's management plan is adapted to the inpatient setting, continuing any community based goals that may assist with timely discharge from inpatient services
- The community case manager will maintain contact with the consumer and participate in care and discharge planning, advocacy and support.

4.5 WACHS MH Management roles and responsibilities: Support for CM

WACHS MH management will support case managers by ensuring:

- Clear processes are established for allocation of consumers to case managers
- Responsibilities of the role are well defined and communicated
- Regular supervision of case managers clinical work load and oversight of case managed consumers to ensure;
    - Clinical work load does not impede the ability of the case manager to provide holistic and recovery-focussed care
    - The management plan is being followed and updated in accordance with the consumer's needs
    - Documentation is completed in line with current standards and overarching policy
    - The consumer, carer and/or family are involved in care planning and management to the extent that the consumer wishes
    - Professional support is available for case manager as required
- Access to ongoing learning and professional development, inclusive of clinical supervision, is supported and available
- Access to systems of documentation and to clinical and other tools for measurement/rating and analysis of the outcomes/goals of CM
- Access to technologies and other equipment that support efficient CM functioning.

5. Compliance

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

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

6. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System.

7. Evaluation

Evaluation of this policy is to be carried out by the WACHS Director of Psychiatry Adult / Older Adult every three years at minimum.

8. Standards

National Safety and Quality Healthcare Standards – 2.10, 5.13, 5.14, 6.3, 6.4

National Standards for Mental Health Services – 1.10, 1.17, 6.6, 6.7, 6.11, 7.2, 9.1, 10.3, 10.4

9. Legislation

Mental Health Act (MHA) 2014

10. References

Charter of Mental Care Health Principles 2014

11. Related Forms

State-wide Standardised Clinical Documentation

12. Related Policy Documents

WACHS Adult Psychiatric Inpatient Services – Referral, Admission, Assessment, Care, Treatment and Discharge Policy

13. Related WA Health System Policies

State-wide Standardised Clinical Documentation SSCD for Mental Health services

14. Policy Framework

Mental Health

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

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