



# Australian Mental Health Care Classification

Mental health phase of care guide

Version 1.2

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## Mental Health Phase of Care Guide

### Mental health phase of care guide

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## Mental Health Phase of Care Guide

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### Document Location

An electronic copy of this document is stored on the network and may be obtained by the IHPA Office of the CEO.

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## Mental Health Phase of Care Guide

### 1. Purpose and Scope

The purpose of this document is to provide the definitions, guide for use and guiding principles for the application of the new concept of mental health phase of care that forms part of the Australian Mental Health Care Classification (AMHCC).

This document provides practical guidance on how to assess the mental health phase of care for a consumer.

This document should be read in conjunction with the following resource material developed to assist in the implementation of the AMHCC:

1. The Activity Based Funding Mental Health Care Data Set Specifications (ABF MHC DSS) 2016-17 technical specifications and associated metadata on METeOR, and
2. The AMHCC User Manual which provides additional background to the development of the new classification, explains the data elements and collection protocols, reporting requirements, and how the data is grouped.

### 2. Background

The mental health phase of care concept was developed in 2012, through a project commissioned by the Independent Hospital Pricing Authority (IHPA). This project identified possible cost drivers for further examination and considered options for a classification architecture. Throughout the project over 500 stakeholders were consulted on all aspects.

The proposed architecture segregated an episode of care into defined mental health phases of care. The episode of care is defined as the period between the commencement and completion of care characterised by the mental health care type<sup>1</sup>. The new concept of mental health phase of care was initially tested in the Mental Health Costing Study, a national study that involved 26 hospital service sites across Australia.

The mental health phase of care concept was also tested in the AMHCC pilot in late 2015, at four hospital service sites across Australia. The following guide was originally trialled in the pilot and has since been further refined through additional consultation to ensure mental health phase of care is adequately described.

Within this guide there are also a series of exemplars provided that were developed by experienced clinicians to offer guidance in assigning the mental health phase of care to a consumer. These exemplars are constructed to describe a range of symptoms, behaviours and functional abilities that consumers may experience while in contact with services and bear no relationship to real people or events.

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<sup>1</sup> [meteor.aihw.gov.au/content/index.phtml/itemId/614240](http://meteor.aihw.gov.au/content/index.phtml/itemId/614240) (accessed on 30 May 2016)

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### 3. Definition

The mental health phase of care is a prospective description of the primary goal of care for a consumer at a point in time. While many factors can impact on the consumer's mental health care plan, the mental health phase of care is intended to identify the primary goal of care by the treating professional(s) through engagement with the consumer. The mental health phase of care is independent of both the treatment setting and the designation of the treating service, and does not reflect service unit type. The setting in which the consumer is treated depends upon the level of risk, the responsiveness of the consumer to engage with services, treatments and supports, and the type of care to be delivered.

A new mental health phase of care may begin either when a consumer commences an episode of care or when the primary goal of care changes in an existing episode of care. Mental health phase of care should therefore be considered as a subset of an episode of care, meaning that for each episode there can be multiple mental health phases of care. The clinician's description of the mental health phase of care is not a replacement for a comprehensive mental health care plan.

There are five mental health phases of care:

- Acute
- Functional gain
- Intensive extended
- Consolidating gain
- Assessment only

The concept of mental health phase of care forms part of the AMHCC which also includes the collection of the Health of the Nation Outcomes Scales (HoNOS), a brief measure of the severity of consumer's problems, and the Life Skills Profile (LSP-16), a measure of consumer functioning. The mental health phase of care concept provides additional information describing the complexity of the consumer's presentation and the primary goal of care.

### 4. Further development

The classification development work has been undertaken with considerable clinical and stakeholder input including two public consultation processes that were undertaken in January 2015 and December 2015. During the second public consultation process, several submissions proposed the need to further investigate the needs of child and adolescent consumers in relation to the concept of mental health phase of care. The evolving requirements for child and adolescent consumers, the diverse range of services required to satisfy the needs of child and adolescent consumers and the need to coordinate these services during any transfer of care were raised as issues that could have a significant impact on how to apply mental health phase of care within clinical practice.

IHPA is committed to the further refinement of the mental health phase of care and has commenced a program of work involving child and adolescent mental health services which will inform Version 2.0 of the AMHCC.

The consultation process also identified the need to determine the inter-rater reliability or the consistency with which different clinicians identify a consumer's mental health phase of care when provided with the same information. IHPA has committed to undertake an inter-rater reliability study of the mental health phase of care in late 2016. This study will provide

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understanding of the reliability of the mental health phase of care definitions and enable the refinement of the AMHCC supporting materials.

The information contained in this document relates to the implementation of the AMHCC. Further work is being undertaken to align the AMHCC with the existing National Outcomes and Casemix Collection (NOCC) protocols.

### **5. Acknowledgements**

Thank you to members of the Mental Health Working Group (MHWG) and members of the Mental Health Classification Expert Reference Group (MHCERG) for their guidance and support.

Thank you to Dr Coombs for his assistance in refining this document along with his guidance on testing the inter-rater reliability of the new concept mental health phase of care.

Thank you to the staff from the four AMHCC pilot sites (New South Wales, Queensland, South Australia and Tasmania) and the 21 organisations that provided submissions to the AMHCC public consultation paper 2 highlighting areas for development and refinement.

## **6. Mental Health Phase of Care Instrument**

This instrument reflects the primary goal of care documented within a consumer's mental health treatment plan at the time of collection (prospective assessment).

**Acute:** The primary goal is the short term reduction in severity of symptoms and/or personal distress associated with the recent onset or exacerbation of a psychiatric disorder.

**Functional Gain:** The primary goal is to improve personal, social or occupational functioning or promote psychosocial adaptation in a consumer with impairment arising from a psychiatric disorder.

**Intensive Extended:** The primary goal is prevention or minimisation of further deterioration, and reduction of risk of harm in a consumer who has a stable pattern of severe symptoms, frequent relapses or severe inability to function independently and is judged to require care over an indefinite period.

**Consolidating Gain:** The primary goal is to maintain the level of functioning, or improving functioning during a period of recovery, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently. Consolidating gain may also be known as maintenance.

**Assessment only:** The primary goal is to obtain information, including collateral information where possible, in order to determine the intervention/treatment needs and to arrange for this to occur (includes brief history, risk assessment, referral to treating team or other service).

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### 7. Guide for Use: Mental Health Phase of Care

These descriptions are simply to be used as a guide and are not meant to be an exhaustive list. Making a mental health phase of care rating requires clinical judgement and consideration given to meaningful consumer engagement. When in doubt, discuss the consumer's mental health phase of care with a senior colleague or a wider multi-disciplinary team.

| Phase of Care | Goal of Care   | Consumer's Unique Characteristics  | Clinician Activity or Expectation  | Indicators of Phase Start   | Indicators of Phase End   |
|---------------|--|--|--|---|---|
| <i>Acute</i>  | Reduce intensity of symptoms and manage risk associated with mental illness. | Consumer has complex symptoms and/or high levels of behavioural disturbance. | <p>Consumer may require an increase in intensity of visual observations or increased monitoring by clinician to maintain safety.</p> <p>Need for urgent risk assessment and management.</p> <p>Consumer may require a low stimulus environment.</p> <p>The consumer's family or support network may require additional assistance.</p> <p>Activities undertaken in an acute phase of care are designed to reduce the intensity of symptoms.</p> <p>Recovery/Treatment/ Care or Management plan is highly dynamic.</p> <p>Phase expected to last days to weeks.</p> | <p>Increasing impact on behaviour, distress associated with psychiatric symptoms. Increased risk of harm to self or others.</p> <p>Change in intensity requiring greater observation and contact with the clinician.</p> <p>Care plan focuses on interventions associated with symptom reduction and/or risk management as well as comprehensive documentation and recovery focused care.</p> | <p>Reduction in symptoms and/or risk, requiring less intensive observation or intervention.</p> <p>Focus moves from symptoms to functional improvement.</p> |

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| <b>Phase of Care</b>   | <b>Goal of Care</b>  | <b>Consumer’s Unique Characteristics</b>  | <b>Clinician Activity or Expectation</b>   | <b>Indicators of Phase Start</b>  | <b>Indicators of Phase End</b>   |
|------------------------|--|---|--|---|--|
| <i>Functional Gain</i> | Improvement in functioning by gaining confidence and mastery in self-management, psychosocial adaptation and vocational performance through structured training and therapy. | Consumer is less distressed by symptoms and is further seeking or would benefit from greater psychosocial activity. | <p>Assessment is concentrated on psychosocial functioning.</p> <p>Recovery/Treatment/ Care or Management plan is focused on development of the consumer’s living and/or interpersonal skills.</p> <p>Phase expected to last weeks to months.</p> | <p>Focus is less on symptom reduction and management, but more directed towards improvement in consumer functioning.</p> <p>Care planning includes group or individual work that focuses on individual, occupational or social functioning.</p> | <p>Increasing need for interventions associated with symptoms or increasing distress</p> <p>Functional improvement that requires longer term intervention.</p> <p>Symptom mitigation requiring greater clinical input.</p> <p>Primary goal of care shifts to self-managing psychosocial engagement in the absence of regular clinical input.</p> |

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| Phase of Care             | Goal of Care   | Consumer's Unique Characteristics   | Clinician Activity or Expectation  | Indicators of Phase Start   | Indicators of Phase End  |
|---------------------------|--|---|--|---|--|
| <i>Intensive Extended</i> | Symptom mitigation /Functional Improvement/ relapse prevention strategy development. | Prevention/minimisation of further deterioration or risk of harm in circumstances where there are frequent relapses, a severe inability to function independently and/or minimal personal understanding and acceptance. | Recovery/Treatment/ Care or Management plan is focused on reducing symptoms and improving psychosocial functioning.<br><br>Phase expected to last months to years.   | Focus of clinical input includes management of symptoms and functioning.<br><br>Both symptoms and function require longer term clinical input.<br><br>Care plan focuses on supporting improvement or preventing deterioration.<br><br>Significant symptoms and poor psychosocial functioning are an ongoing issue requiring intensive clinical input. | Management of symptomology and distress levels, become the primary focus of clinical concern.<br><br>Increasing risk of harm requires risk mitigation and management.<br><br>Improvement of symptomology and psychosocial functioning. |
| <i>Consolidating gain</i> | Plateau of symptoms and maintenance of functioning.                                  | Psychiatric symptoms continue but are not distressing nor pose significant risk to consumer or carer.   | Monitoring of symptoms and functioning occurs on a regular basis.<br><br>Optimise level of functioning and promote recovery to assist community integration and independence.<br><br>Phase expected to last months to years. | Symptoms and functioning are stable but ongoing inputs from services are still required.  | Symptoms and consumer distress are the focus of clinical concern.<br><br>Increasing risk of harm, requiring additional risk mitigation.<br><br>Reduction in symptomology and improved ability to self-                                 |

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| Phase of Care          | Goal of Care  | Consumer’s Unique Characteristics   | Clinician Activity or Expectation   | Indicators of Phase Start  | Indicators of Phase End   |
|------------------------|---|---|---|--|---|
|                        |   |   |   |  | manage psychosocial engagement in the absence of regular clinical input.  |
| <i>Assessment only</i> | <p>Information gathering to enable assessment of an consumer</p> <p>Or potential referral for treatment services if required.</p> | <p>Consumer presents seeking assessment or has been referred from another agency.</p> | <p>Completion of a mental health assessment to determine if referral for treatment is required.</p> <p>Collection of collateral information.</p> <p>Initial management planning focused on the identification and referral to alternative services.</p> <p>Phase expected to last hours.</p> <p>This phase is not intended to capture regular review as part of a standard clinical workflow routine.</p> <p>This phase was developed to capture the significant amount of work that occurs for people who do not necessarily go on to formal episodes of care.</p> | <p>Symptoms or distress experienced by the consumer or family member or friend result in help seeking behaviour.</p> <p>Phase occurs on first contact with a service where a mental health assessment is needed, to determine if any further intervention is required.</p> | <p>Information collection, interview, observation, collateral history gathering, formulation, initial management plan and referral have been completed.</p> <p>Further care needs have been identified.</p> |

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### 8. Guiding Principles for Use in Practice

- 8.1 The rating of the mental health phase of care should be undertaken by the clinician with best understanding of the consumer's presentation and need for intervention. This would typically be the case manager or primary clinician.
- 8.2 The mental health phase of care should be assessed on admission/registration to a service, where there has been a transfer of care between service settings or when there has been a change to the mental health care plan as outlined in 8.3.
- 8.3 When there is a significant or substantial change to the consumer's symptoms and/or psychosocial functioning that requires a change to the mental health care plan, a review of the mental health phase of care should occur.
- 8.4 Mental health services should conduct regular reviews of the consumer's treatment, care and recovery plan, whether involuntary or voluntary, as per clinical standards of operation. This includes change of mental health legal status, transfer between service sites and deterioration in symptoms/ functioning.
- 8.5 The mental health phase of care does not need to be assessed and identified at every contact made with the consumer by a care provider.
- 8.6 A review of the consumer's mental health phase of care may be undertaken part way through an episode within the assigned phase of care but does not have to lead to a change in the mental health phase of care.
- 8.7 If a change in mental health phase of care is required, this should be accompanied by a change to the mental health recovery/ treatment/care or management plan and be clearly documented in the consumer's medical record.
- 8.8 A change in mental health phase of care of a consumer must be recorded in the consumer's mental health care plan to reflect changes in mental health phase status.
- 8.9 At the commencement of, or a change in a mental health phase of care, an outcome measures collection is required in all mental health service settings as per clinical guidelines.
- 8.10 There is no set time period for the length of a mental health phase of care, however regular reviews of a consumer's mental health phase of care should occur as clinically appropriate. The mental health phase of care does not need to be changed at each review when the main goal of treatment remains the same.
- 8.11 There is no limit on the number of mental health phases of care in an episode of care. An episode of care may contain one or multiple mental health phases of care.
- 8.12 If a consumer is referred to another setting, the "Assessment Only" mental health phase of care may be reported to capture the work undertaken at the service in conducting the brief triage assessment or initial assessment.
- 8.13 Although a consumer is reviewed regularly throughout an episode of care, "Assessment only" can only ever be the first or only mental health phase of care in an episode.
- 8.14 The AMHCC does not require the completion of outcome measures for an "Assessment Only" mental health phase of care, however all other mental health phases of care require the completion of outcome measures.

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- 8.15 If outcome measures are completed at the commencement of an “Assessment only” mental health phase of care then these can be deemed completed for the first collection of a subsequent mental health phase of care if considered appropriate.
- 8.16 A consumer will only have one mental health phase of care at any time. When care is co-managed or provided by multiple mental health services in the same setting, the mental health phase of care should be agreed upon by the various treatment providers. The mental health care plan should include all activity undertaken by all relevant treatment providers in that setting, and the mental health phase of care should align with this care plan.
- 8.17 Mental health phase of care cannot be changed whilst a consumer is on leave from a health care service (i.e. when a consumer is on holidays).
- 8.18 As the mental health phase of care is prospective the reporting of discharge measures is not required in relation to the AMHCC.

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### **9. Examples of Phase of Care**

These examples are to be used as a guide to demonstrate each mental health phase of care and provide possible indicators for changes a consumer may experience in their mental health phases of care. These exemplars follow the adult mental health phase of care for ease of demonstration in the assignment of mental health phase of care per consumer. Mental health phase of care is applicable to all age groups and the inter-rater reliability study will assist in the development of age-appropriate case vignettes.

## Mental Health Phase of Care Guide

### **Acute**

#### **Mental Health Phase of Care**

##### **Name:**

David is a 32 year old single male.

##### **Behaviour:**

Your first contact with David is in the Waiting Room, where he has attended with his mother. He appears dishevelled, unkempt and appears to be responding to non-evident stimuli. At times he is quite animated and seems intermittently perplexed and distraught. He is often seen talking to himself and appears distressed by these experiences. His mother reports that she has been very upset by David's recent aggression towards her and states that "every time I try to talk with him he flies off the handle". She says that he will raise his voice and looks like he is going to hit her. "That isn't like him at all", she says. He denies drug and alcohol use except for the "occasional beer" though his mother reports that he has been "drinking a lot lately". He denies thoughts of self-harm.

##### **Physical:**

David has gained considerable weight in recent months. He spends most of his time inside, either on the lounge or in his room. He smokes up to 25 cigarettes a day and would smoke more if he had the money. David also repeatedly picks at sores on the back of his hands.

##### **Symptoms:**

David received a diagnosis of Schizophrenia when he was aged 19 years. During your interview, David admits to hearing voices that comment aggressively about the behaviour of people around him. He does not believe that medication does anything to help him. During your interview he becomes very animated and is clearly distressed by the non-evident stimuli. David reports that he sometimes has trouble with his memory and working out change when he buys things

##### **Social:**

David lives in a small converted garage behind his mother's house. His mother tends to do all the house work as he can't seem to manage it himself. David has two older siblings who are not supportive and criticise their mother for 'babying' him.

##### **Interventions:**

David is visited fortnightly by his community Case Manager (CM) who administers Risperdal Consta 50mg IMI. His last dose was given a week ago. At his brothers' insistence, his mother called the CM to discuss his recent behaviour.

##### **Rationale for Acute Mental Health Phase of Care:**

The primary goal in this phase of care is reduction in the distress caused by the auditory hallucinations and their impact on David's behaviour.

##### **Possible indicators for Mental Health Phase of Care change:**

- David is less distressed and preoccupied with Auditory Hallucinations (AH), appears less agitated and expresses an interest in joining a local gym. **New Phase - Functional Gain**
- The AH's persist and remain troubling and he requires a sustained focus on supporting improved psychosocial functioning. **New Phase - Intensive Extended**
- Although AH persist, David's response to them appears less pronounced. David continues to accept his medication although he says he doesn't really need it. **New Phase - Consolidating Gain**

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### **Functional Gain**

#### **Mental Health Phase of Care**

##### **Name:**

Lauren is a 35 year old female in a long-term relationship.

##### **Behaviour:**

Following an initial referral and assessment, it is decided to register Lauren as a consumer within the service. Lauren reports that she continues to have difficulty attending her workplace and avoids contact with other parents after school. Lauren says that "I know I have to be there for my daughter now that she is at school" and is seeking help with this. Lauren describes having a "glass of wine" of an evening to help her relax. She denies thoughts of self-harm.

##### **Physical:**

Lauren says that she is not walking as much as she once did, as she has not been going to work in the past few weeks. She feels that her type 2 Diabetes may not be as well controlled as it once was when she was exercising regularly.

##### **Symptoms:**

Lauren reports that she sometimes feels so anxious in social situations that she feels like she might faint. She has tried some basic relaxation techniques with some success but thinks there might be better ways of managing her anxiety. Lauren reports that she finds herself having to make lists to remind her of what to do each day.

##### **Social:**

Lauren lives with her husband who claims he is very supportive. Lauren's husband travels a lot for work but has attended one appointment with her assigned case manager to learn how to best support Lauren. Lauren's extended family distanced themselves from Lauren and her husband over a family dispute several years ago. However, Lauren's next door neighbour has committed to walking to school with her and her daughter in the mornings and helping with childcare when Lauren attends appointments.

##### **Interventions:**

Lauren is enrolled in a structured CBT program at the community centre which includes individual and group work. Lauren's husband is provided with education. A referral is made to provide carer/family support.

##### **Rationale for *Functional Gain* Mental Health Phase of Care:**

Lauren is an active participant in seeking out and engaging in her care. She shows good personal understanding and acceptance about her condition. She identifies appropriate and meaningful goals for her care.

##### **Possible indicators for Mental Health Phase of Care change:**

- Lauren is unable to return to work and her symptoms do not improve with the completion of the CBT program. ***New Phase - Intensive Extended***
- Lauren returns to work and reports that she would like to return to her GP for ongoing care and support. ***New Phase - Consolidating Gain***
- Lauren reports that she is experiencing frequent and distressing thoughts of self-harm. ***New Phase - Acute***

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### ***Intensive Extended***

#### ***Mental Health Phase of Care***

##### **Name:**

Peter is a 38 year old single male.

##### **Behaviour:**

Peter was diagnosed with a Bipolar Affective Disorder 20 years ago. Peter lives in a shared house with two other men. He is unemployed and struggles financially. He left school before completing Year 10 and has had a series of jobs, ranging from roofing contractor to telesales but has lost them after short periods due to his unpredictable behaviour. His mood and behaviour are erratic. He requires frequent reminders to attend review appointments and to take medication. He has a history of mood swings, and often an inflated sense of his own importance as well as impulsivity and recklessness.

##### **Physical:**

For the past few months, Peter has been drinking up to a carton of beer every two days. He is overweight and reports that his girlfriend teases him that he “has a beer belly like her Dad”. Peter smokes ‘roll your own cigarettes’ and has nicotine stained fingers.

##### **Symptoms:**

Peter’s mood is changeable and his behaviour is erratic; he blames the mental health service for “making me like this”. Peter’s girlfriend reports that he “argues with everyone” and that the police have been called to his unit when he has been intoxicated. He says that he keeps losing his ATM cards and forgets his PIN.

##### **Social:**

Peter’s house-mates are aware of his mental health diagnosis and describe his recent behaviour as “pretty typical.” Although he is behind on his rent, they remain generally supportive. His girlfriend says he likes going to music gigs with her and “it’s the only time he seems happy”.

##### **Interventions:**

Peter is seen by his CM on a regular basis. His CM has been actively trying to engage Peter with a local job agency that has a program designed to provide people with supported employment. Peter’s housemates and girlfriend are provided with education and support.

##### **Rationale for *Intensive Extended Mental Health Phase of Care*:**

The goal of Peter’s care is to minimise further deterioration and decrease his risk of self-harming behaviours while improving his functional ability over time.

##### **Possible indicators for Mental Health Phase of Care change**

- Peter’s mood stabilises with medication and psychological support and he gains casual employment as a furniture removalist which he likes. ***New Phase - Consolidating Gain***
- With the help of his CM, Peter participates in the supported employment program and would like to participate in a financial management program in the near future. ***New Phase - Functional Gain***
- Peter is picked up by police and taken to the Emergency Department after threatening to kill his flatmate while under influence of alcohol. ***New Phase - Acute***

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### **Consolidating Gain**

#### **Mental Health Phase of Care**

##### **Name:**

Roberta is a 64 year old woman.

##### **Behaviour:**

Roberta presents as an older woman who is quite vibrant and engaging. She is casually and appropriately dressed, though wearing a lot of makeup. She is talking animatedly with the receptionists prior to seeing you and has to be gently reminded to stay on track during your conversation. She denies thoughts of self-harm or drug or alcohol use.

##### **Physical:**

Roberta has visible rosacea on her nose and cheeks and has commenced treatment for this by her long standing family GP. Changes to her diet were suggested and she has noted a marked improvement to her eating habits. She has found it a challenge to make dietary changes, as she was brought up eating traditional Italian dishes.

##### **Symptoms:**

Roberta was diagnosed with Bipolar Affective Disorder over 30 years ago after a number of hospitalisations for Depression in southern Italy where she was born. She had been unable to work in the family accountancy business for many years. Her mood had stabilised significantly in the previous 12 months and she has been working in the family business as a receptionist. Roberta reports that her mood is stable and that she is sleeping through the night, only getting up once to go to the toilet. She reports that the medication sometimes makes her tired in the mornings. She has also started going to an aqua-aerobics class organised by the local community centre and this has helped with her tiredness. Roberta's son expresses annoyance that she forgets people's names or where things are kept like her shoes or tea bags.

##### **Social:**

Roberta lives with her son and his wife, since her husband passed away four years ago and has a large circle of friends. She reports that she gets on well with the other employees of her son's firm as she has known them for many years. Though she reports that it has been "a very big change" to be living with her son, she feels that she has adapted. However, Roberta's son and daughter-in-law do not like that Roberta lives with them as she is becoming increasingly forgetful and her constant reminiscing is annoying.

##### **Interventions:**

Roberta attends the local community centre on a regular basis. The family have also been involved with a carer support service for education around Roberta's condition and support. The carer support service suggested that Roberta's son provide his employees with information from the local community centre about Bipolar Affective Disorder. This has not happened to date.

##### **Rationale for *Consolidating Gain* Mental Health Phase of Care:**

The prospective goal of care is to promote recovery and to continue to assist Roberta to optimise her level of functioning and to meet her personal goals of continuing to work regularly with her son's business.

##### **Possible indicators for Mental Health Phase of Care change:**

- Roberta's mood has been low for over 6 months and is not responding to treatment. She complains that the medication is making her tired at home and she is unable to help her son and daughter-in-law with the housework. She has been reluctant to go to work. ***New Phase - Intensive Extended***

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- Roberta reports that she is not able to go to work as her concentration is failing her and she is making too many mistakes with the appointment bookings. ***New Phase - Functional Gain***
- Roberta presents to the Emergency Department after a fight with one of the employees at her son's business. She believes that this woman has been stealing from her purse and also talking about her behind her back. Roberta's son provides conflicting information relating to his mother's recent experience in the workplace. ***New Phase - Acute***

## Mental Health Phase of Care Guide

### **Assessment Only**

#### **Mental Health Phase of Care**

##### **Name:**

Peggy is a 28 year old married mother.

##### **Behaviour:**

Peggy has been referred to your service by her GP. She has a 3 year history of depression and anxiety. She appears slightly anxious and reports that she sometimes feels sad. In social settings she says she gets “very panicky” and will sometimes leave in a hurry because of this. Her youngest daughter has just started school and she is very worried about meeting with her teachers and other parents. She has had difficulty sleeping and describes a number of strategies her counsellor “told me to try” to help her sleep. She denies thoughts of self-harm. She describes herself as a social drinker, “but I am not really interested”.

##### **Physical:**

Peggy has type 2 Diabetes, diagnosed when she was 22. She has changed her diet since her diagnosis and walks to the shops regularly as well as to her work as a receptionist at a local dentist three days a week. She feels that this is helpful in managing her diabetes.

##### **Symptoms:**

Peggy reports that she sometimes feels very sad, often for days at a time. She takes any personal criticism to heart and often finds herself withdrawing from conversations and feeling like she is being judged unfairly. She denies psychotic phenomena. Peggy says she is “normally pretty sharp” but finds her attention wandering when she is cooking.

##### **Social:**

Peggy lives at home with her husband and two young children. She has a strongly supportive extended family network. Peggy reports that she has been off work for a week due to her anxiety and she feels that her medication is no longer working. Peggy’s husband agrees with this view.

##### **Interventions:**

Peggy has been seeing a psychologist following a referral by her GP, but she isn’t sure that this is helping “as he wants to talk about things I don’t think are important”. An anxiety management group offered by a local church is an option that interests Peggy.

##### **Rationale for Assessment Only Mental Health Phase of Care:**

The goal of Peggy’s care was to determine what level of mental health care was required and to provide feedback and advice to her referring GP.

##### **Possible indicators for Mental Health Phase of Care change:**

- Peggy feels unable to return to work and her social withdrawal increases. The goal of care becomes more intense, aimed at reducing her social isolation and ability to return to work. **New Phase - Functional Gain**
- Peggy’s distress and anxiety is persistent and interventions aimed at reducing social isolation are not successful. Sustained multidisciplinary input is required to prevent further deterioration. **New Phase - Intensive Extended**
- Peggy begins to utilise skills acquired in small group settings and has a graduated return to work. **New Phase - Consolidating Gain**
- Peggy presents to the local Emergency Department while intoxicated and expresses thoughts of self-harm. **New Phase - Acute**

## 10. Frequently Asked Questions

|   | Question  | Response   |
|---|---|--|
| 1 | A consumer who is managed by a case management team for a long period of time has become rapidly unwell during the course of their care, requiring closer supervision. The consumer will still be managed by the case management team however care has been temporarily transferred to the acute care team over the weekend, due to lack of staff resourcing to provide appropriate care. The consumer will return to the case management team when there is more staffing available after the weekend. Is this a change in phase of care over a two day period and would this warrant a completion of additional outcome measures? | <p>This would not require a change to the phase of care.</p> <p>The collection of an outcome measure is not mandated; however as part of clinical practice, outcome measures may be collected anytime as clinically indicated.</p>   |
| 2 | In an encounter, the usual first point of contact is the acute care team. After receiving services from the acute care team, consumers may be transferred to a case management team where the phase of care may be the same or different. If the phase of care is the same does an outcome measure need to be completed?  | <p>An additional outcome measure is not required as it is about the consumer and not the treatment provider.</p> <p>However, if the phase of care is changed, an outcome measure will be required. For example, when a consumer becomes rapidly unwell and the main goal or aim of care has changed.</p>   |
| 3 | Some consumers may be seen by a primary case management team and a secondary team (for example, rehab, working with families, transition teams and Clozapine clinics). In accordance with the outcome measure protocols, responsibility for completing outcome measures rest with the primary team. Secondary teams are not required to complete an additional set of outcome measures. If the secondary team is a rehab team and the phase of care of the rehab team is different to the phase of care of the primary team should an additional set of outcome measures be completed?  | <p>The phase of care should align with the mental health care plan for the consumer. The mental health care care plan for the consumer would normally reflect the activity that was being undertaken by all relevant teams therefore the phase of care should not be different for the various treatment providers. As a result there be additional outcome measures would not need to be collected.</p> |

## Mental Health Phase of Care Guide

|   | <b>Question</b>   | <b>Response</b>  |
|---|---|--|
| 4 | A consumer in the admitted setting may be followed-up by their case manager from the ambulatory setting. Similarly, a consumer may be admitted to a general ward and followed-up by their treatment provider/case manager from the mental health unit. In both scenarios, how is the 'secondary' provider acknowledged? | The consumer's mental health care plan should reflect the activity undertaken by all relevant teams and the phase of care should not be different for the various treatment providers. |