Department of Health
Incorporating: Health, Mental Health and Ageing

50 Lonsdale St
Melbourne
Victoria 3000
GPO Box 4541
Melbourne
Victoria 3001
Telephone: 1300 253 942
Facsimile: 1300 253 964
www.health.vic.gov.au
DX 210311

Our Ref: PSD 13 413
Your Ref: COR 2010 000952

24 December 2013

Ms Clare Coate
Coroner's Registrar
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Coate

Re: Investigation into the death of Jeffrey S Whitling

Thank you for providing me with a copy of the findings including recommendations into the death of Mr Jeffrey S Whitling.

In response to the relevant recommendations made by the Coroner:

Recommendation 1
That NWMH:

- *Implement the changes outlined in its Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers bulletin; and*
- *Update and upload its Continuity of Care in Transfer and Discharge policy to include the relevant information – or reference thereto – in the Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers bulletin.*

Response
This recommendation is not directed to the Department of Health.

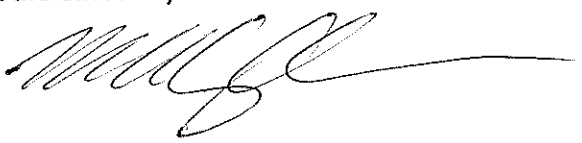
Recommendation 2
That to increase the safety of patient who have an extensive history of disengagement when discharged from involuntary status under the Mental Health Act, I recommend that NWMH and the Office of the Chief Psychiatrist work together to review the appropriateness of, and opportunities for, including information from NWMH's Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers in the Discharge Planning for Adult Community Mental Health Services guidelines.

Response
An alternative to the coroner's recommendation will be implemented.

The Department wishes to draw the Coroner's attention to the Department's *Discharge Planning and the Development of Protocols between Adult Mental Health Services and General Practitioners* program management circular. This program management circular is aimed at improving discharges from Area Mental Health Services to General Practitioners. The Department will update this program management circular to incorporate information referred to in NWMH's *Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers* that specifically refers to the discharge of patients with extensive histories of disengagement and non-compliance. Once updated this program management circular will be disseminated to Area Mental Health Services and placed on the Department's website.

Please let me know if I can provide any further information.

Yours sincerely



Dr Mark Oakley Browne
Chief Psychiatrist

Attachment
- *Discharge Planning and the Development of Protocols between Adult Mental Health Services and General Practitioners* program management circular

Discharge planning and the development of protocols between adult Area Mental Health Services and general practitioners

Program management circular

Key message

Discharge planning is a key component of the care delivered by adult Area Mental Health Services (AMHS). This circular builds on the foundation of the *National Standards for Mental Health Services* and the Chief Psychiatrist's Guideline *Discharge planning for adult community Mental Health Services*. The protocols apply to consumers receiving community mental health services both in the medium to longer term as well as those who enter the AMHS via a short-term, inpatient admission and are then discharged to GP care.

Purpose

To provide advice about improving discharge planning practices and the development of protocols between area mental health services (AMHS) and general practitioners (GPs).

Background

In late 2004, each AMHS received funding for an additional community mental health clinician. This funding was designated to assist AMHS improve discharge processes to GPs. Frequently, people are discharged to a GP from an AMHS for ongoing treatment. In order to improve continuity of care and health outcomes for people transferring from an AMHS to a GP, AMHS may need to re-visit their existing discharge planning policies and procedures and establish protocols with GP divisions and/or GP practices, where they do not exist.

This summary of the requirements for developing protocols and improving discharge planning should be read in conjunction with the attendant background paper 'Discharge planning and the development of protocols between Adult Area Mental Health Services and general practitioners'.

Protocol development

- Each AMHS will be responsible for developing a discharge protocol with their local GP Division, outlining the agreed process for the transfer of care, including discharge, support and re-entry processes.
- Each adult AMHS will utilise existing organisational structures within their service to further progress discharge planning.
- Input should be sought from consumer and carer representatives, along with representatives from local GP divisions and AMHS.
- A working party should be convened for a time-limited period to facilitate improvements to discharge planning processes and a protocol.
- Where Primary Care Partnership systems and practices are in place, discharge planning processes should be integrated with them.
- All protocols should integrate those aspects in the Enhanced Primary Care (EPC) and Better Outcomes in Mental Health initiatives, which can contribute to improved discharge planning.

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Principles of discharge planning

Discharge can be a time-intensive aspect of case management. The responsibilities of AMHS in discharge planning can be summarised into four key areas. They also overlap with the criteria mentioned in the *National Standards for Mental Health Services* and the Chief Psychiatrist guideline:

- Engage in collaborative discharge planning at an early stage of treatment with the person, their carer/s, key AMHS and external stakeholders involved in the person's treatment and care.
- Provide written and verbal treatment-related information for the person being discharged and their carers.
- Provide written and verbal treatment-related information for GPs and other service providers involved in the person's care .
- Provide timely communication with consumers, carers, GPs and other key stakeholders.

The above stakeholders may include AMHS multidisciplinary staff, private psychiatrists, GPs, Psychiatric Disability Rehabilitation Support Services and other health or community service staff. Although a designated AMHS staff member is usually the key contact for the GP regarding a given consumer, other multidisciplinary clinical staff should contribute to the discharge planning as appropriate.

Phases in discharge planning

Discharge planning is a progressive process that can be seen to involve a series of phases.

(a) Preparation phase

- Develop criteria for determining those consumers whose ongoing needs can be met by transferring their continuing care to a GP.
- Incorporate the discharge process as part of the existing internal multidisciplinary case review processes in each AMHS.
- Develop strategies to identify and document a consumer's GP on their registration sheet and relevant care planning documentation; where consumers will not have a regular GP, or tend to move from practice to practice, introduce strategies to support consumers to engage with one GP or practice.
- Identify the varying roles and levels of responsibility for GPs and AMHS staff depending upon the person's needs and the GP's interest or experience in dealing with persons with a mental illness.

For a variety of statutory, treatment-related or practical reasons, there will be some consumers, who will not be able to have their continuing care needs fully provided for by a GP.

(b) Implementation/transition phase

Discharge is a 'staged' process in which care is transferred to the GP while involvement from the adult AMHS is diminished over time. Issues to consider include:

- Varying the nature and length of the transition period according to the history and care needs of the consumer.
- Identifying people with complex needs, who may need a transition phase before the GP can fully support them.
  - People, who have received extensive care from the specialist mental health service system may require a transition up to 12 months.
  - For this group, it is expected that a number of planned contacts from the AMHS will occur with the consumer and their GP, including at the end of the transition phase.
  - Following this review, it should be considered whether to proceed to 'full' GP care, extend the transition phase, implement shared-care treatment arrangements or re-engage the consumer back into AMHS.

(c) Full GP care phase

The ability to assume full care will be enhanced when, as part of the discharge planning process, the GP:

- collaborates with all stakeholders in developing the discharge plan
- is actively involved in the ongoing management of the consumer
- participates in the planned meetings with the AMHS and the consumer during the transition phase
- assumes the provision of medication as appropriate, with reviews as the consumer's condition or needs change; this may include medication review by the AMHS psychiatrist at the GP's request
- is sensitive to the consumer's ability to pay.

If the person's needs appears to change post discharge and their existing plan becomes inappropriate to their needs, assistance or advice can be sought by the GP from the AMHS.

Within a six month post-discharge time frame, AMHS should in most circumstances accept GP-initiated referrals of consumers who have received comprehensive care from a specialist mental health service over an extended period of time. Where the AMHS is concerned about the suitability of such a referral, negotiations need to occur between the GP and the specialist mental health service. In these circumstances, the AMHS should ensure that the consumer maintains treatment while the situation is being resolved.

About program management circulars

The information provided in this circular is intended as general information and not legal advice. If mental health staff have queries about individual cases or their legal obligation under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

Content of a discharge plan

It is suggested that discharge plans to GPs include summarised details about:

- the consumer's past and current psychiatric history, including any risk factors and the current extent of recovery
- past and current biopsycho-social treatments and their responses
- treatment goals and a recovery plan, together with management recommendations
- early warning signs of relapse and risks, such as frequent missed appointments or the re-emergence of symptoms
- medical and non-medical strategies for managing early warning signs, including whom to contact if a relapse is suspected
- the consumer's involvement with other agencies or service providers
- the support that will be provided by the AMHS to each GP
- a brief statement of the consumer's and carer/s' knowledge of the condition and the management, including treatment adherence and self-management
- contact details of key workers and where appropriate, carer/s
- information about how to refer in situations of psychiatric crisis or to obtain a second opinion.

Further information about mental health discharge planning and protocol development can be obtained from Basia Sudbury:

Phone 9616 8305 or email basia.sudbury@dhs.vic.gov.au

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