



YOUR GUIDE TO CONTINUING CARE SERVICES

Mental Health, Drugs & Alcohol Services



**Barwon
Health**



PRINCIPLES

Relationship Focussed
Tailored Care
Effective Teams
Innovative Approaches

Assessment

Planned
Care

Evidence
Informed
Practice

Consumer
Engagement

Family/Carer
Engagement

Supported
Decision
Making

Outcome
Monitoring

Transitions
& Transfers

OUR GOALS

- ✓ Consumers feel better
- ✓ Care is accessible and connected
- ✓ Consumers feel well treated
- ✓ Consumers feel safe and are safe
- ✓ Carers feel included

You can use this guide to help you understand what to expect from your team.



YOUR TEAM CONTACT DETAILS

Your Primary Clinician

Name:

Contact Number:

Your Consultant Psychiatrist

Name:

Contact Number:

Other Contact Numbers

Number to call when Primary Clinician is not available:

Number to call in emergency:



ABOUT CONTINUING CARE SERVICES

What is Continuing Care Services?

We are one of the treatment teams at Barwon Health's Mental Health, Drug & Alcohol Services (MHDAS). We are sometimes also called CCS.

Why am I with Continuing Care Services (CCS)?

'Continuing Care' means you will visit us over a longer period of time, not just once or twice. You have been referred to CCS for assessment to see if continuing care is the best treatment pathway for you at this time.

What will I get from CCS?

- CCS is based on a model of Family Mental Health. This means we recognise the impact that your environment, family, carers, supports and community can have on your mental health and wellbeing. We will consider these factors as part of your treatment and recovery conversation, and use them for building the right supports around you.
- You will receive help from our team to improve or maintain your mental health and wellbeing.
- You will receive your treatment whilst you remain living within your community.
- We will also support your carers, family and loved ones, as they support you.

What if I need additional supports?

Help will be available if you:

- Don't have access to technology
- Need disability access
- Need transport
- Need an interpreter
- Have specific sensory needs

What if I need additional information?

You can ask any of your CCS treatment team for further information.

What if I have any concerns or complaints?

You can contact the Barwon Health Consumer Liaison Officer either by post, or phone, or via an online feedback form on our website.

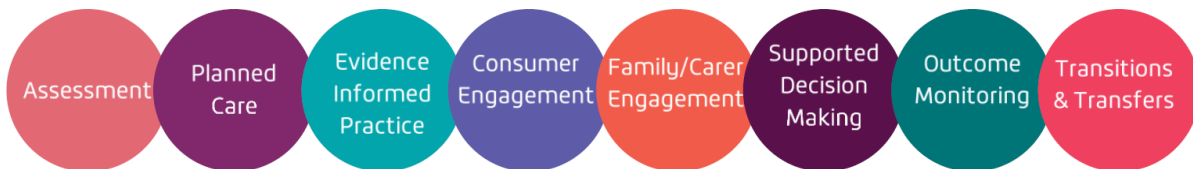
Mail: PO Box 281
University Hospital Geelong,
Bellerine Street, Geelong VIC 3220
Phone: (03) 4215 1251

You can also contact the Victorian Health Complaints Commissioner.

YOUR CCS TREATMENT

What is treatment?

The following eight parts sit behind your treatment journey. More information on each part is provided on the following pages.



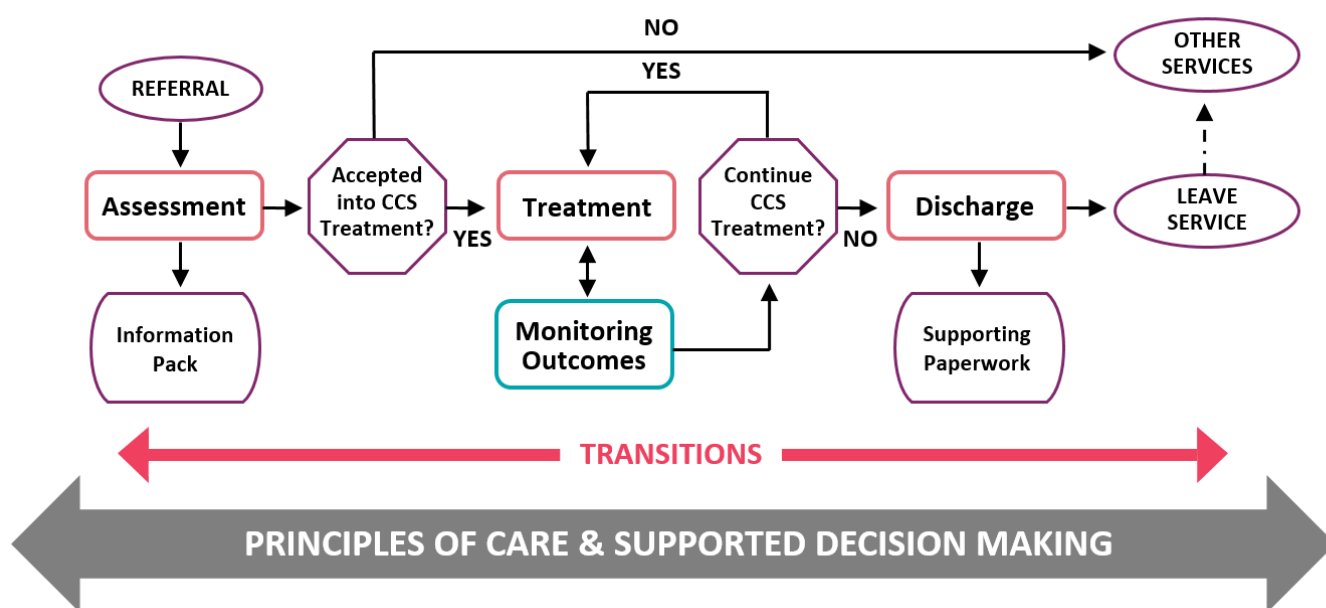
How will my journey start?

Your journey will start with speaking to a clinician for a CCS assessment. We will work with your previous teams and supports to minimise the need for retelling your story.

What will my treatment journey look like?

Your journey starts with an assessment phase. The diagram below shows your journey.

Our treatment recognises you as a unique individual with changing needs. That's why the steps shown below may not always happen in a straight line. Your treatment and care plan will continuously evolve with you on your journey.



ASSESSMENT

What is assessment?

Assessment is the process of finding out why you're here and which types of treatment might suit you best. Assessment is an ongoing process, it is not expected to be completed in one session.

Where will you do my assessments?

First appointments and urgent assessments will normally be made face-to-face, in a hospital or a clinic near you. In some situations, we may be able to send someone out to meet you. Follow up appointments may take place in person at one of our clinics, or via telehealth (meaning over the phone or a video call).

How will you do my assessment?

We will normally ask you (and your family/carer, if needed) a number of questions including any previous medical, mental health, physical and family history. This will help us understand:

- Your physical and mental wellbeing
- Any alcohol or drug use
- Any supports you currently have, or may need
- Which things currently work for you and which don't
- What you'd like to get out of your treatment

We will build on information you have already shared with other parts of MHDAS to enable continuity of care and minimise you unnecessarily retelling your story.



ASSESSMENT

Who will be doing the assessment?

Assessment helps build the relationship between our staff, you and your carers. The person doing the assessment may include one (or all) of the following:

- a. Suitably qualified clinician/s
- b. Psychiatrist
- c. Psychiatric Registrar
- d. Junior Medical Officer

Can I bring anyone else along with me?

Having other people who know you present in the room also helps us to understand you better. You may ask to bring anyone with you to help you feel safe and supported, such as:

- a. Family;
- b. Friends or other people you trust;
- c. Carers, guardians or support workers; and
- d. Other external professionals.

What will happen after assessment?

On completion of the Assessment (within one month) the following will be documented:

- Assessment summary
- Formulation of presenting issue/s
- Risk formulation
- Treatment and Care Plan (a copy of this will be given to you)
- Acute Presentation Plan (if required)

PLANNED CARE

How is my care planned?

Your care is based on the principle of 'Right Care, Right Time and Right Place'. Based on your personal circumstances, we will work together to determine the following:

- Right Care – A care plan tailored to you
- Right Time - How often we will be in contact with you, and your family/carer
- Right Place - Where (and how) that contact should take place. (e.g. face to face, telehealth).

What is a Care Plan?

A Care Plan is sometimes called a Treatment Plan. They mean the same thing. A Care Plan includes all aspects of your treatment, including when, where and how treatment will be provided. Your Care Plan will be reviewed regularly.

Why do I need a Care Plan?

Your Care Plan is based on your experience and your needs, values, preferences and circumstances. This needs to be written in one central place so that all health care professionals can access this information and minimise the need for you retelling your story.

Who else may be involved in the development of my Care Plan?

Where required, we will involve other supports like:

- a. Family;
- b. Friends or other people you trust;
- c. Carers, guardians or support workers;
- d. CCS Peer Support Worker;
- e. General Practitioner; and
- f. Other external professionals.

How often is my care plan reviewed?

Your care plan should be reviewed every 90 days.

Who will be involved in the review of my care plan?

Your care plan will be reviewed in partnership with:

- a. You
- b. Your primary clinician
- c. Your Consultant psychiatrist
- d. Carer/Support person.

EVIDENCE INFORMED

What is Evidence-Informed Practice?

Evidence-Informed Practice is a process for making informed clinical decisions about your care. These research-based decisions about your care are tailored to meet your individual needs, preferences, and cultural expectations. All treatments provided are supported by national and international standards.

All CCS clinicians are expected to use Evidence-Informed Practice in your care, and are required to have an understanding of the following areas of practice that can influence your experience:

- a. Recovery-oriented practice
- b. Trauma-informed care
- c. Developmentally-informed practice
- d. Attachment informed practice
- e. Family-inclusive practice
- f. Mental Health Act

How does it impact you?

Your clinician will include evidence-informed therapies in your treatment plan, in discussion with you.

Why do these therapies need to be included in your treatment plan?

These therapies can help you feel better and achieve your goals in addition to your regular supports and medication.

Who will provide these therapies to you?

These may be delivered by your primary clinician within CCS or a specialist may be engaged.



CONSUMER ENGAGEMENT

What does consumer engagement mean?

Consumer engagement means we will connect and work with you to design your care. Your care will be designed based on a model of partnership and therapeutic engagement. This means we spend quality time with you and aim to empower you to actively participate in your own care.

Who is responsible for this?

The responsibility for this partnership is shared between you and the CCS team. It is important that you engage with the CCS team for the greatest chance of success in your treatment. It is equally important that the CCS team engages with you to make sure treatment options are effective and safe for you.

When does the team start engaging with me?

This starts from your first contact with CCS, all the way through to discharge. This contact aims to keep you fully involved and informed in all aspects of your care.

What will the service do to engage me?

In your first 28 days we will work with you to

- Identify your support person
- Ask you to complete a consent form for sharing information with your identified support person
- Explain your rights and responsibilities
- Provide you with names and roles of key staff involved in your care
- Provide you contact details to use when you are not feeling well or need help.
- Develop an early warning signs document with you

What about my carer or support person?

We recognise family members, friends and carers also play a crucial role in supporting your recovery. This may be your immediate family (like mum and dad), friends you trust or a formal support such as an NDIS support worker or guardian.

We understand that families/carers may have specialised knowledge of your journey and can provide significant input and insight into designing your treatment plan.

How will CCS engage my supports?

Where you consent, we will keep your carers up to date with your treatment. They may also attend your reviews and appointments with you.

What if my carer or support person needs help?

Your family or carer may also have their own needs for information, support and development of skills to continue to support you. We can help them link in with these resources.

FAMILY/CARER ENGAGEMENT

What does family/carer engagement mean?

Your family members, friends and/or carer ('Carer') may play a crucial role in supporting your recovery. We also understand that your Carers have their own needs for information, support and development of skills to continue in their role. That's why it is important that we actively engage with both you and your Carer.

When does the team start engaging with your Carer?

Any engagement with your Carer is carried out in partnership with you. Once we receive your signed consent, we will initiate contact with your Carer.

What will the service do to engage your Carer?

Within the first 28 days we will:

- Organise an initial meeting with your Carer.
- Determine their willingness and ability to provide support.
- Complete a "Family/carer to receive and share consumer information" consent form.
- Provide your Carer with names and roles of key staff involved.
- Provide your Carer contact details to use when you need help.

As part of Ongoing Care, we will:

- Collaborate with you and your Carer to develop a Treatment and Care plan.
- Offer and hold family meetings as agreed between the clinician, you and your Carer.
- Continue to make sure they are able and willing to continue in their role as Carer.

On discharge from the service

- Determine your Carer's willingness and capacity to continue current care/support arrangements.
- Determine level and type of supports required for your Carer to continue in their role.
- Involve your Carer in development of early warning signs document and relapse prevention plan, and provide relevant education.

How will the service support your Carers?

We will conduct an initial family/carer needs assessment. This includes:

- Understanding if this is their first experience with the mental health system.
- Identify their needs for support, safety and education.
- Share details of appropriate carer support mechanisms.
- Offer and arrange debrief session after significant events, like admission into the CCS.

SUPPORTED DECISION MAKING

What is Supported Decision Making?

Through Supported Decision Making, we help you to make and communicate decisions about your treatment. Supported decision making is your right under the law. The Mental Health Act directs the CCS team to protect your dignity and personal choice. The Act says “persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.”

We take a number of steps to make sure Supported Decision Making can happen, including:

- giving you enough time to make decisions;
- involving your carers;
- providing information in different forms (such as written or verbal); and
- including advocates, such as Peer Support as approved by you.

By using supported decision making, we aim to achieve ‘informed consent’ which is when you agree to the treatment presented to you after understanding all of the risks and benefits involved.

What is a Substitute Decision Maker?

In very rare situations a ‘Substitute Decision Maker’ may be appointed. This occurs through a specific request from the health service to the Victorian Civil and Administrative Tribunal (VCAT). This request will only be made if the CCS team finds you are unable to make decisions about your life (such as finances, lifestyle and medical decisions) and have no other decision maker already appointed or contactable. They must also prove to VCAT that this inability is likely to be ongoing, is specifically related to mental health, and that urgent decisions need to be made to progress your treatment.

What is an Advance Statement?

An Advance Statement is a statement of your treatment preferences made when you are well.

Why are Advance Statements helpful?

This statement can be used to ensure your treatment preferences are known in situations where you become too unwell to communicate them.

OUTCOME MONITORING

What is Outcome Monitoring?

Outcome Monitoring is a process to gather information about you and make sure your pathway to recovery is working for you. As a part of Outcome Monitoring, you may be asked to complete questionnaires about your experiences. You can also provide feedback about how you are feeling at any point along your treatment journey.

How will this help you?

It is important to have things in place to track your progress. Monitoring outcomes provides good feedback for you, your supports and your clinicians on how you are doing and what else is needed to support your recovery.

They also allow us to monitor our services and continually improve the treatments that we offer, and allow you to hold us accountable.

How will we collect and document this information?

At the start of your journey and then every 90 days your clinician will give you a questionnaire that you will complete. These are also called 'Consumer Rated Outcome Measures'. These questionnaires are designed to assess the symptoms and difficulties you are experiencing, and whether the current treatment is helping you to address these. The results will support your team to work with you and your carers to design and change your treatment plan to make it as successful as possible.

What if you do not want to complete these Consumer Rated Outcome Measures?

It is completely up to you. You may choose to not complete the questionnaire. We will continue to offer you the chance to complete them every 90 days during your journey with us. You can still provide feedback to your team at any time.

TRANSITIONS AND TRANSFERS

What is the difference between 'Transition' and 'Transfer'?

Transition means exiting you from our care. It is also called 'Discharge'. This is done when you reach a stage in your journey where you no longer feel as though you need any support, or where you have developed ongoing supports in your local community (for example, your own GP).

Transfer means that your care is being transferred to another MHDAS team, based on your needs at the time.

How will CCS support you during Transition?

We know that transitions can be quite difficult for you and your carers, as it may mean working with different people or accessing different services in other locations. Because of this, we work very hard to coordinate these transfers to minimise the stress on you and your carers, and reduce the need for you to repeat your story.

How am I Transitioned out of CCS?

We start planning for your Discharge from CCS services from your first assessment. This makes sure that we are always working towards getting you to a point where your symptoms are manageable and you have the right supports in place.

We will work with you to make sure:

- Any paperwork you need to support your ongoing care (such as for NDIS or VCAT applications) is given to you before you are discharged.
- We tell your carers, support services and other parties before you are discharged. Where possible this will be via verbal exchanges and/or face-to-face meetings.
- We inform other services such as DHHS, family violence, corrections or a Guardian/ Administrator (if this applies to you).

At discharge, the CCS team will give you

- A copy of your relapse prevention plan,
- A list of crisis contacts for you to use in an emergency,
- A copy of your medication list

You may also receive an official discharge letter.

What if I become unwell again after discharge?

Depending on your situation, you may:

- Refer to your relapse prevention plan.
- Contact Your GP.
- Contact Your Support worker (if you have one).
- Ring Mental Health Phone Triage Number 1300 094 187.
- In case of Emergency, ring 000 or go to Emergency Department.

