

## **WA JOINT CONSUMER ADVISORY GROUPS**

### **ISSUES PAPER SERIES – PAPER TWO**

#### **Continuity of Care in the Community and Hospitals for People with a Mental Illness**

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It is generally acknowledged that there is room for improvement when it comes to the issue of continuity of care for people with a mental illness. For example in a recent report: "Duty to Care: physical illness in people with mental illness" it states that 'More integrated and cooperative approaches to health care are required to effectively meet all the needs of people with a mental illness' (UWA, 2001)

At present there is considerable discontinuity between hospital treatment and fragmented post-hospital support in the community. We all know that this often results in preventable relapse in the consumer and ends up costing more in the long run. In terms of a costs-benefits analysis, the smooth operation of the continuity of care principle must lead to a more functional and efficient mental health service and fulfil the consumer's right to a substantive quality of life which includes notions of wellness and recovery.

#### **Guidelines**

In terms of guidelines for the implementation of the continuity of care principle we have several publications: The Mental Health Statement of Rights and Responsibilities (AGPS, Canberra, 1991) and The National Standards for Mental Health Services (AGPS, Canberra, 1997) to name just two of the main guides. Space prevents going into detail here, however two of the principles in the former publication will be highlighted. The first is that 'every person admitted to a mental health facility or community program has the right to adequate discharge planning' and secondly that 'the consumer has the right to have explicit standards set for all sectors of service delivery and that such standards should have operational criteria by which they can be assessed'.

Currently the Mental Health Act 1996 only canvases this issue in terms of 'minimal requirements and does not define best practice'. Perhaps a case could be made for concretising a more functional notion of continuity of care within the next Mental Health Act and proudly giving this some legislative focus.

The National Standards, which contains many salient recommendations, must be complied with by 2003. However there has been minimal activity to progress this compliance. The guiding principle is that continuity of care should be achieved through the development of intersectorial links between mental health services and other organisations.

Before its demise, the Metropolitan Mental Health Service introduced guidelines to service providers which attempted to improve discharge planning. Some hospitals and clinics apparently discussed these guidelines but there is yet to be a substantive indication of change.

### **Discharge Planning**

Discharge planning must take into account the provision of a seamless transition from acute care to community living. This requires communication within and between agencies. There are glaring examples of lack of communication between agencies. In one rural/remote setting, a country town small enough for everyone to know everyone's business, a mental health consumer received three injections in one day instead of one fortnightly injection from three different health services in the town. The danger of this lack of communication between agencies cannot be understated, and if it can happen this easily in a small country town what are the implications for city services where anonymity between agencies is preserved and the likelihood is that such an action could go undetected.

Action should be taken to enhance communication between agencies. It is suggested that an outreach team (including someone with social work skills) be put in place in each public service, and be part of the multidisciplinary team treating the consumer. The outreach team could link the agencies in the community, the consumer and the services. The outreach team should not be confined to static agencies but could also link with services such as the Division of General Practice Street Doctor programme to enhance continuity of care with homeless consumers. Interested psychiatric registrars could also contribute by working with this service.

With the introduction of 'shared care' between GPs and the mental health services communication between practitioners is vital. Education of GPs regarding mental health and early signs of relapse should be paramount and psychiatrists should make themselves readily available for consultation with GPs and the consumer.

### **Step Down Facilities**

The transition between hospital and home also needs to take into account the provision of 'step down' facilities. A consumer may not need hospitalisation but cannot endure their psychosis at home or a consumer may be well enough to leave hospital but not well enough to cope in the community. 'Step down' facilities similar to the Hampton Road Service in Fremantle should be available in each region, although the Hampton Road Service bears too great a resemblance to the hospital setting. Whatever is considered, the fluctuating state of a consumers health should be accommodated in a 'safe house'.

### **Community nurses**

Community nurses play a key role in the transition from hospital to the community. At present the role of the community nurse is broken up into that of assessor, clinician, therapist, educator, consultant/advisor/advocate and manager. In recent years, community nurses have been working in pairs for security reasons. This has effectively halved the efficacy and reach of the community nurse and the heavy caseload brings about the scenario where the community nurses' visit, if you are lucky enough to get one, is limited to a few moments where medication is checked. The incidence and distribution of community nurses should be greatly expanded.

### **Accommodation**

The accommodation problem is another key indicator of the need for continuity of care to be prioritised in a person's transition to community living. It is not just homeless consumers who have an accommodation problem even though this is the most obvious issue. There may be consumers whose accommodation is untenable. The lack of space prohibits discussion but if Disability Services can work effectively towards housing in the community, Mental Health Services should also be able to develop appropriate community living for consumers.

The fragmented service currently available has considerable cost to both the consumer and the mental health services. The consumer pays in terms of their right to a substantive quality of life and the services pay considerable amounts of money for preventable relapses. Continuity of care and outreach services are the key to cost saving measures.