Discharge Information Group at New Farm Clinic

PIR Agency:	Footprints
Date:	February 2015 – June 2016
Key issue(s)	There appears to be a significant gap in the provision of ongoing community care post discharge from private hospital settings. Many clients appear/report to receive a very limited level of assistance to link in with community based services at the time of discharge from New Farm Clinic. It is also evident from discussions with stakeholders that not all patients are allocated to a social worker upon discharge. This results in frequent hospital readmissions and, presents as a barrier to such clients' recovery.
Main Objective(s)	The objective of this system reform project is to establish a Discharge Information Group (DIG), in partnership with New Farm Clinic. This group is to take place fortnightly at New Farm Clinic, in collaboration with the clinic social worker Janie Gibbons. It is intended that the DIG will provide a space for New Farm Clinic patients to discuss their recovery goals, and their needs in the community post discharge. The PIR Coordinator will offer referrals to Partners in Recovery for eligible participants, as well as provide referral information for other community based supports. For participants who are not eligible for PIR but require support to engage with alternative services, social worker Janie Gibbons will use the DIG as an opportunity to engage, and provide support upon discharge.
Summary of Impact or Result	- A strong relationship has been built with the on-site social worker, Janie Gibbons; who intends carry out each DIG in partnership with the PIR Coordinator. - It has been confirmed that the project has received full endorsement from the Clinical Director of services at New Farm Clinic. - Patients at the clinic are becoming increasingly aware of the presence of a DIG, due to ongoing promotional support fromm Janie Gibbons. - 3 DIGs have taken place thus far. Evaluations completed by participants indicate that the group has provided valued information about potential community supports available and appropriate referral pathways. - On occasions the DIG has taken place, links with the on-site social worker for discharge support have been made, where it is evident that such participants may not have otherwise received social work input. This suggests the DIG provides an opportunity for participants to link in with support prior to discharge, who may otherwise have 'fallen through the gaps'. - 2 referrals have been made to PIR during the initial 3 DIGs.
Context	
It is evident that the vast majority of private sector mental health clients are re-entering hospital settings to access further support, rather than utilizing community based services. This presents the issue that private mental health clients' recovery is at risk of being hindered by the potential for them to become institutionalized, and buy into notions of a "sick" rhetoric. It is this reforms aim; to make community based services more accessible to such clients. This initiative will promote their recovery via the access of community based supports. It is hoped that this will decrease the rate and prevalence of private sector clients becoming acutely unwell, whilst also reducing their reliance on inpatient settings.	

Supportive data:

- Data gathered by the World Health Organization which contrasts several Mental Health Care models has indicated a *"balanced care approach"* is generally most effective. A balanced care approach favors the notion that inpatients should be supported to access community based services upon discharge. This approach also encompasses a strong focus on formalized relationships between private and community based services, to ensure the interfaces between them function effectively (Thornicroft G, Tansella M (2003) *What are the arguments for community-based mental health care?* Copenhagen, WHO Regional Office for Europe, Health Evidence Network report; http://www.euro.who.int/document/E82976.pdf).

- Recent reports from the Australian Institute of Health and Welfare provide that approximately 14% of people, who access inpatient psychiatric facilities in Queensland, are readmitted within 28 days of their discharge date. This indicates that either their treatment was incomplete or ineffective, or they did not receive adequate support to access community based services (Australian Institute of Health and Welfare 2015. Mental health services—in brief 2015. Cat. no. HSE 169 Canberra: AIHW).

These statistics are consistent with the observation in Brisbane Metro North that many patients in private settings do not receive adequate information about community based supports. Such patients are often aware of clinical services available to them, but receive a limited level of referrals to non-government organizations.

Target group:

- Clients with a history of frequent hospital admissions due to lack of community supports.

- Clients who access hospital as a respite option, or the safest destination for them to be at that time.

Setting:

- New Farm Clinic

Stakeholders/Partnerships	

- Partnership developed with on-site social worker Janie Gibbons.
- Introductions have taken place with ward nurses, who have agreed to participate in promotion of the DIG.
- Endorsement of New Farm Clinic and PIR partnership has been provided by the New Farm Clinic Director of Services.

Project Management	

The project is managed collaboratively between PIR Coordinator Jonathon Coles, and New Farm Clinic social worker Janie Gibbons.

PIR Coordinator tasks have included:

- The creation of a brochure to be distributed amongst patients and ward staff at New Farm Clinic.
- Providing an on-site referral pathway to Partners in Recovery.
- Establishing a lay out for the group process and facilitating discussion at each DIG.
- Offering information with regards to relevant community based services.
- Keeping record of a fortnightly contact sheet.
- Distributing and keeping record of participant evaluation forms.

New Farm Clinic social worker tasks include:

- Promoting the availability and purpose of the group to patients in the lead up to each DIG.
- Facilitating the access of an appropriate space for each DIG to take place.
- Facilitating on the spot linkage with a clinic based social worker for participants, as and when required.
- Providing follow up support with referrals identified in the DIG for participants who are unable to

engage with community based services in the absence of support.

One particular challenge which was a barrier to the implementation of the DIG was staff turnover in the PIR team. The PIR Coordinator who commenced this project moved on from PIR shortly after the plan was completed. As a result, there was a significant period of time between the documentation of the Systems Reform plan and the implementation of the DIG. Further to this, the initial PIR coordinator experienced difficulty during attempts to build a partnership with New Farm Clinic. It is evident that this was largely due to the previous on-site social worker's lack of interest or availability to be involved in the project. Following handover to the current PIR Coordinator, contact was made to Janie Gibbons who has played a fundamental role in achieving endorsement of the DIG at New Farm Clinic.

Description of Activities	

As this project is currently in the initial stages of implementation, the activities untaken thus far have been primarily focussed on relationship building/developing a partnership, as well as promotion of the DIG, formalising a process of how the groups will run and a short period of trial and evaluation.

<u>Relationship building/developing partnerships:</u>

- Discussions with New Farm Clinic based social workers – pitching the objectives of the system reform project and the benefits of trialling a Discharge Information Group.
- Distributing the system reform plan to clinic based social workers and the Clinical Director of Services.
- Attending an initial meeting at New Farm Clinic with social worker Janie Gibbons for discussion around the scope of the project and potential implementation process.

<u>Promotion:</u>

- Development of a 'New Farm Clinic Discharge Information Group' flyer.
- Provision of the DIG flyer to New Farm Clinic ward staff, for distribution amongst patients.
- Provision of PIR brochures for distribution at New Farm Clinic.

<u>Pilot and determination of process:</u>

- Offering flexibility with regard to the delivery of the DIG – originally it was intended that participants would engage with the PIR Coordinator one by one, however; it was evident following the pilot, that given the patients were used to and more comfortable with group work, there was a strong preference for the DIG to operate via similar model. The process was subsequently adapted to meet the preferences of the participants.
- Establishing time frames – the space provided at New Farm Clinic is only available for one hour. Therefore the group needs to run by distinct time frames. The time has been divided in two components; the first half hour providing a chance for each participant to share their primary support needs, and the second half hour is focussed on drawing out key themes and providing appropriate referral pathways. Participants are then encouraged to liaise with the PIR Coordinator after the group, if they would like to discuss their eligibility for PIR.

<u>Evaluation:</u>

- Attendance and numerical data keeping via the completion of a fortnightly Summary of Contact Sheet.
- Distribution and collection of evaluation sheets to be completed by participants at each DIG.

Project Impact	

Given that at this point in time, only 3 Discharge Information Groups have taken place at New Farm Clinic; it is difficult to make well informed observations regarding the impact of the project and any long term outcomes. However, the feedback gathered via evaluation forms has indicated the DIGs have been extremely beneficial, and have provided participants with valued information about community based support options.

Quantitative data was gathered via a fortnightly contact sheet, the most significant of which is detailed in

the table below:

Quantitative data of patient interactions to date	
Total number of DIGs carried out	3
Total number of participants to date	18
Total number of referrals to PIR	2
Total number of referrals made to other agencies/services	26
Total number of instances information was provided on different community based service types	28
Total number of instances where participants were marked for follow up from an on-site social worker	7

Key Findings: This data shows an average of 12 instances of referrals to community based support services per group. In addition to this, the DIGs have been markedly beneficial in linking patients in with social work input, who may not have otherwise been brought to the social worker's attention. It also should be mentioned that there was a much higher attendance rate for the initial DIG than the subsequent two. This was likely due to the significant level of promotion from the on-site social worker prior to the pilot. This has been discussed and stakeholders are in the process of mapping how to make this level of promotion more consistent, to ensure patients are aware of the group times.

Further to the above, a limited amount of qualitative data has been gathered via participant evaluation forms. Although only 9 evaluation forms have been completed by participants to date, some key themes are evident in the information gathered:

- 100% of the participants who completed evaluations rated the group between 8 and 10 out of 10, with regard to usefulness.
- The majority of the evaluations indicated that participants felt they now had access to community based supports which they had otherwise been unaware existed.
- The majority of the evaluations indicated participants left the group feeling more confident about continuing work towards their recovery goals upon discharge.
- Suggestions for improvements indicated a running theme of desire for the group to be longer in duration.
- Suggestions for improvements indicated a desire for a higher level of knowledge regarding community based services outside of Brisbane.

Direct quotes:

"Everyone had the chance to voice their own personal needs. The information provided was fantastic and gave me lots of avenues to look into, as well as eased the stress associated with transitioning from hospital to home"

"Inpatients should be told that this group is massively helpful"

"Well organised. Gave me confidence that there is support available in the community"

"Very informative – good communication and information"

"Perhaps a longer session would be better"

"More pamphlets and brochures would be appreciated".

Lessons Learned	

- The success of the DIG has been contingent upon the willingness of New Farm Clinic staff to collaborate and contribute to its implementation.
- Attendance of the DIG is largely dependent on fortnightly promotion – Janie Gibbons has agreed to

ensure ward staff are aware of each DIG and promotional activity can remain consistent. - Participants have requested longer group times – Janie Gibbons has agreed to explore an alternative space which may be available for longer at the time of each DIG. - Participants have requested more pamphlets and brochures to take aware with them – PIR Coordinator to source pamphlets to take to upcoming DIGs.	
Appendices	