July 2009

Protocol for Inner West Area Clinical and PDRSS services regarding working relationships with regard to referral and the continuum of shared care.

The Inner West Area Alliance has developed a solid partnership to ensure communication and coordination in order to develop a cohesive rehabilitation and recovery system for consumers in the Inner West catchment area.

To date the Alliance has developed an MOU, conducted studies on current levels of communication and implemented shared professional development forums and orientations for staff across all partner services.

This protocol provides guidance for minimum levels of communication and coordination between services in order to foster a more effective working relationship towards the development of a cohesive rehabilitation and recovery package for shared consumers.

The partners of the inner west alliance have agreed to the protocols included within this documents

1. Referral from Inner West AMHS-RMH to PDRSS

1.1. When referring a consumer to a PDRSS the referring clinician will, whenever possible, obtain consent from the consumer prior to the referral.

1.2. Informed consent to share relevant information will be sought from a consumer by all participating agencies, and active participation by the consumer will be encouraged.

1.3. When consent is not given, an engagement strategy will be initiated to enable the consumer to meet with PDRSS worker, and consent to be obtained as part of the engagement strategy.

1.4. The clinician will refer using the SCTT (Service Coordination Tool Templates) tool and other standardized tools, eg. Specialist assessment, as required by the PDRSS, and respond promptly to requests for further information required by PDRSS at intake.

1.5. E-referral will be used when the electronic transfer of information is secure and the IT systems are established. Where these systems are established the E-referral will occur using the Health & Community Services Directory website at www.connectingcare.com.

1.6. Clinical staff will ensure high priority referrals are flagged adequately and PDRSS intake will ensure high priority referrals are processed within 1 week.

1.7. Clinical staff will provide information about identified and potential risks to the consumer, to staff or any other person. A copy of the clinical risk assessment will be provided at the point of referral.

1.8. If there is any change in circumstances of the consumer during the referral period the clinician will inform the PDRSS of these changes.

1.9. PDRSS will provide written feedback, where possible, regarding the outcome of the referral within 2 weeks.

2. Referrals from a PDRSS to Inner West AMHS-RMH

2.1 When referring a consumer to the AMHS the referring PDRSS worker will, whenever possible, obtain consent from the consumer prior to the referral.

2.2 The PDRSS worker will refer new and previously case managed consumers to the triage worker

2.3 All referees must speak directly with a triage worker.

2.4 Where the electronic transfer of information is secure and the IT systems are established, referring workers will complete SCTT tools and use connecting care for referral.

2.5 PDRSS staff will include information that will assist in prioritizing the level of need and/or urgency.

2.6 PDRSS staff will provide information to the AMHS about identified and potential risks to the consumer, to staff or any other person.

2.7 On acknowledge of receipt of referral the AMHS will advise the PDRSS of the time frame required to process and action the referral.

2.8 The AMHS will advise the PDRSS of the outcome of the referral, and provide explanation regarding rejected referrals. Secondary consultation will be available for PDRSS services in the management of people not accepted for direct clinical service.

2.9 If there is any change in circumstances of the consumer during the referral period the PDRSS worker will inform the AMHS of these changes.

3. Shared responsibilities for Referral

3.1 6 weeks following the acceptance of a referral a communication meeting is to be held between PDRSS and clinical services to discuss;

- Progress towards early treatment/service goals
- Initial treatment/service plan
- Roles and responsibilities of clinical and PDRSS staff
- Potential adjustments to each plan

3.2 Each agency will appoint a referral liaison to serve as a contact point for pre-referral consultations for consumers potentially entering PDRSS residential programs. The liaison will be available to provide advice regarding referral criteria, and likely outcomes of a proposed referral.

4 Entry

4.1 Consumers entering partnership services shall be made aware that services are not offered on an indefinite basis, in line with program / service provision requirements.

4.2 Consumers will be informed, about a. Service Criteria, b. Engagement review and c. Exit planning.

4.3 On entry to either service the AMHS and the PDRSS will exchange as a minimum the following:

- Date of entry to the service.
- Service/program type.
- The name and contact details of an appointed case manager/key worker who I is the consumer's primary contact within the service.
- The names and contact details of family and/or carers and any other agency involved in the provision of services to the consumer (eg. GP's, housing agencies, etc.)
- Consent to release information

4.4 Workers shall encourage consumers to recognize that collaboration and information sharing between key health service providers is important to provide/obtain optimum service delivery.

4.4.1 The key worker/case manager will discuss with the consumer what information will be shared between services within the bounds of Privacy Legislation, the Mental Health Act, including Section 120A, any agency policy guidelines and obtain consent.

4.4.2 The consumer will be informed under what circumstances their rights to privacy and confidentiality will be waived.

4.4.3 Consent will be specific to named agencies rather than workers, shall be for no more than 12 months before renewal and will specify the parameters of the information to be exchange.

4.4.4 The key worker/case manager will also discuss with the consumer what information will be shared with families and/or carers.

4.4.5 The consumer will be made aware that they can revoke their consent at any time.

4.4.6 Where the consumer's preferred language is other than English consent will be sought in accordance with DHS language services policy.

5 ISP Development / Shared Care

5.1 A service planning meeting will be held within 6 months. PDRSS, Clinical service, consumers and carers will be invited to attend.

5.2 Mental Health services and PDRSS services will exchange as a minimum the following information:

- Changes of appointed case manager or consumer's key worker.
- Referral to another clinical program.
- Change of address and/or contact details of the consumer.
- Where risks are identified to the safety and well being of a consumer, or staff providing services or to other persons, these will be communicated as soon as possible.
- Current status of any legal orders, eg. Guardianship or Administration Orders, CTO or non-custodial orders, and notice and outcome of any legal hearings, eg. Mental Health Review Board hearings.
- Where there is planned leave greater than 14 days the key worker/case manager is to advise the shared service of any alternate arrangements.
- Unplanned leave greater than 14 days: enquiries go to Team Leaders.

5.3 Key workers/case managers are expected to maintain communication around:

- Assessment.
- ISP development and review including – negotiated planned interventions.
- Significant changes in the consumer's level of needs.
- Triggers, stressors and/or significant changes in mental state or associated behavior.
- Medication and/or treatment changes that may have an effect on the support needs of the individual.
- Significant changes to appointment frequency or non-attendance at scheduled appointments.
- Referral to alternative services.

6 EXIT

6.1 A decision for a consumer's capacity to exit the service should be planned and based on an assessment, taking into account:

- Service demands and prioritization of clinical need.
- Whether the consumer no longer needs or can benefit from the service.
- Further treatment goals.
- Whether key support needs are/can be appropriately met by the consumer and/or alternative supports.
- The wishes of the consumer and carers (as appropriate).
- A collaborative discussion between service providers.

6.2. Planning for leaving Mental Health/PDRSS service will occur whenever possible, in a coordinated and collaborative manner with maximum consumers input.

6.3. Partnership services will explain the criteria that applies for continued receipt of service and the process by which continued engagement with the service will be routinely reviewed to ascertain a person's readiness to commence exit planning.

6.4. Upon commencement of planning for discharge/exit from service, information exchange is expected to occur between the services around the rationale and criteria for proceeding, projected timelines and the development of an exit plan.

6.5. Where a consumer is relocating out of the region services agree to make appropriate referral arrangement to alternate clinical / PDRSS support and to inform each other about the referral action.

6.6. A copy of the discharge plan shall be provided to agencies when consumers exit from programs.

6.7. Consultations will be provided by clinical services regarding discharged consumers as required. Provisions for re-referral will be noted in case closure.

6.8. Each service will operate within the referral criteria and risk framework of their agency. In cases where services are expected to cease (e.g. due to safety concerns), clear information will be provided to all alliance partners.

6.9. Alliance partners will undertake to explore different methods of service delivery prior to ceasing current contact.