

COLLABORATIVE SERVICE ARRANGEMENTS
Private Psychiatrists and Public
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Foreword

The redevelopment of Victoria's public mental health services has created a changed context for the provision of mental health care presenting both challenges and opportunities.

Public mental health services are now an integrated part of the general health care system. A range of community based services are available to people at a local area level and are often delivered alongside other health services. Case management underpins the approach to service delivery and multidisciplinary staffing ensures that a range of skills and expertise can be drawn on to meet the varied needs of people with serious mental illness.

To ensure a coordinated response to the complex needs of people with serious mental illness, public mental health services must increasingly look to develop and maintain effective partnerships with other services and sectors.

Private psychiatrists are clearly a major provider of mental health services. For many they offer a service that is highly individualised, ensures continuity of care over very long periods of time and offers particular expertise in different areas of mental health care. For too long, perceived barriers to cross sectoral collaboration have seen people with mental illness and their families or

other carers, have to make difficult choices about treatment options or service providers, or feel they may have to compromise continuity of care with one service provider to ensure access to a particular services response.

Through working in partnership with each other, public mental health services and private psychiatrists can together pursue better outcomes for people with mental illness. A practical and flexible approach to collaborative service delivery can minimise disruption to continuity of care and ensure a wider range of service options when one service provider cannot adequately meet the range of identified needs.

Cooperative service delivery between public mental health services and private psychiatrists can increase the opportunity to provide services in an appropriate, timely and effective way.

Clearly, further work is required to continue to remove barriers to effective collaboration and interchange between the two service sectors. I am confident that this initiative represents a practical first step toward a more flexible relationship in the interests of consumer outcomes.

Director, Psychiatric Services
Department of Human Services,
Victoria

TABLE OF CONTENTS

1	Introduction
3	What is a Collaborative Service Arrangement?
4	When is a Collaborative Service Arrangement considered?
7	How does it work?
11	Steps towards a Collaborative Service Arrangement
12	Key Roles and Responsibilities
14	Definitions

COLLABORATION

Presents an Opportunity for a More Responsive Service

Introduction

Specialist mental health services in Victoria are delivered by a range of providers within the private, public and non-government service sectors. To ensure the best possible outcomes for patients, it is important that professional service and community linkages and networks are developed and maintained, and where appropriate, formalised with written protocols.

There are longstanding liaison and joint service delivery arrangements between public mental health services and the non-government and community sectors. Current shared care arrangements with general practitioners and with private psychiatrists provide some demonstration of the way public mental health services can also work cooperatively with professionals in private practice. Private psychiatrists have a key role in the provision of specialist mental health services. It is particularly important that a formalised and consistent approach to collaborative work between public and private mental health service providers is developed and promoted.

Multimodal interventions are often required to address the complex needs of people with severe psychiatric disorders, however private psychiatrists face constraints in providing such interventions. Historical and other

factors have meant that generally patients have used either the public or the private sector but not both concurrently. Individuals who are treated by a private psychiatrist should not however have to relinquish that support because they may also need some services from a public mental health service.

The development of Collaborative Service Arrangements aims to:

- promote specific arrangements between public mental health services and private psychiatrists to allow joint service provision to take place if indicated by patient need and professional assessment
- encourage intersectoral service delivery strategies in rural and other areas where constraints exist with regard to the range of services available
- enhance access for individuals with severe mental illness to a wider range of services and opportunities
- ensure continuity of care for patients moving across or between service sector boundaries
- increase the capacity of public and private mental health services to provide responsive, flexible service options for individuals with severe mental illness.

The introduction of Collaborative Service Arrangements provides a guide for the preferred approach to the development of cooperative partnerships between private and public sector services, and presents an opportunity to move towards a more flexible and responsive mental health service system.

JOINT SERVICE PROVISION

Meets Treatment and Support Needs

WHAT IS A COLLABORATIVE SERVICE ARRANGEMENT?

A Collaborative Service Arrangement is an arrangement between a private psychiatrist and a public mental health service that facilitates joint service provision to meet the treatment and support needs of an individual with mental illness.

The arrangement may be initiated by either party, may be time limited or ongoing, and may involve the commitment of resources from the two service providers to achieve the best possible outcome for the patient. In all cases it is important that the means and frequency of communication required to support the treatment aims of the agreed management plan are stipulated, and that a mechanism for review is identified.

It is not necessary for the arrangement to be represented in documentation other than the normal patient records. For public mental health services, Collaborative Service Arrangements will be identified in individual service plans.

A Collaborative Service Arrangement will exist between a private psychiatrist and a public mental health service when:

- there is an agreement for patient management between the private psychiatrist and the Director of Clinical Services (or delegate) of the Community Mental Health Service
- an agreed management plan for the patient is developed defining roles and responsibilities of the key

clinicians—including treating psychiatrist and case manager

- there are mechanisms in place for monitoring and evaluating the service arrangement according to patient need and outcome
- the individual patient understands and agrees to the arrangement.

The introduction of Collaborative Service Arrangements does not alter or preclude the existing practice of:

- referral of patient management from private practitioners to the public mental health service
- referral of patient management from the public mental health service to a private practitioner
- referral as appropriate of any individual requiring Crisis Assessment and Treatment (CAT) services and acute inpatient services.

WHEN IS A COLLABORATIVE SERVICE ARRANGEMENT CONSIDERED?

The primary aim of a Collaborative Service Arrangement is to achieve the best possible outcome for individuals with a mental illness via a service response that meets their needs and reflects their choice.

A Collaborative Service Arrangement can be initiated by a private psychiatrist or the public mental health service when:

- the services available within one service sector cannot adequately meet the needs of a particular patient

and

- the adoption of a joint service

delivery approach will minimise disruption to continuity of care and enhance patient outcomes

and

- the individual patient is aware of the changes to their treatment arrangements this may introduce, and agrees to the process.

ENHANCED PATIENT OUTCOMES
Are Our Primary Objective

CASE VIGNETTE

For the past three years a private psychiatrist has been seeing a 24 year old man, Ray, who has a diagnosis of schizophrenia, and in recent months has begun to increasingly abuse alcohol.

Ray lives at home with his parents and younger brother, although sometimes he will stay with friends for days or weeks at a time. He receives a Disability Support Pension and both he and his family are interested in the idea of some vocational training. On the two occasions that his mother and his psychiatrist have organised a referral to a rehabilitation program for him, he has been staying away from home and drinking heavily, and was unable to keep the appointments.

Ray's behaviour, particularly when he has been drinking, can be unpredictable and at times his family have been fearful of him.

Ray has had four brief admissions to hospital in the past two years, and seems to respond well to early intervention when he has an exacerbation of his psychotic

symptoms. He finds it useful to talk regularly with his psychiatrist, but is ambivalent about the medication he is prescribed and his compliance tends to be erratic.

The psychiatrist recognises that Ray requires further assistance with support and rehabilitation and closer monitoring of his compliance with treatment—he suggests that he transfer Ray's treatment to the local community mental health service where a range of service options are located. Both Ray and his family express concern about a change.

The psychiatrist contacts the community mental health service and enquires about the possibility of joint service delivery to more effectively meet Ray's needs without disrupting the continuity of care now established.

The Duty Worker at the Community Mental Health Centre receives the referral and agrees to take it to the intake meeting for discussion. A decision is taken to accept the referral for a Collaborative Service Arrangement, and a case manager is appointed.

Both the psychiatrist and the case manager, a community psychiatric nurse, agree to meet with Ray in the first instance and discuss with him the changes in his treatment arrangements. With Ray's consent, his family are also invited to this meeting.

The following plan is agreed to:

- the psychiatrist will continue to see Ray on a fortnightly basis and

will manage and prescribe his medication

- the case manager will aim to establish a working relationship with Ray to enable regular supportive contact and the opportunity to make further assessment of his needs for service, particularly in the areas of Ray's understanding and response to his illness, coping strategies, and work and leisure opportunities
- the case manager will involve other members of the multidisciplinary team as necessary for particular assessments or interventions
- in a situation where an urgent assessment or intervention is required, the case manager will discuss a response with the psychiatrist. If the psychiatrist cannot be contacted, the case manager will coordinate a response drawing on whatever resources are necessary within the public mental health service, eg another psychiatrist, the Crisis Assessment and Treatment Service, or the Inpatient Unit.

The psychiatrist and case manager agree to liaise regularly by phone in the initial stages and to meet in three months time to review progress and prepare a detailed management plan.

COOPERATIVE RELATIONSHIPS

Are Fundamental for Successful Treatment

HOW DOES IT WORK?

A Collaborative Service Arrangement is initiated via normal referral mechanisms.

The referring service will discuss

with the patient the plan to seek a Collaborative Service Arrangement prior to making a referral. The referral will only take place with the informed agreement of the individual patient.

Wherever possible liaison will take place with carers, family members and other workers around the development of a Collaborative Service Arrangement. However, it is important that the patient's preferences and choice are respected with regard to who is involved in the process.

Individuals receiving services from the public mental health service will always have a case manager appointed and will be formally registered with that service.

With the establishment of a Collaborative Service Arrangement, the private psychiatrist will work collaboratively with the case manager and other clinical staff of the public mental health service, according to an agreed management plan, to meet the mental health care needs of the individual patient.

The case manager from the public mental health service will work closely with the private psychiatrist as the agreed management plan is developed, and will ensure that individual roles are clearly delineated as part of this plan, as well as roles in urgent or crisis situations.

The Director of Clinical Services (DCS) has responsibility for maintenance of standards of treatment and care as provided by public mental health services. As

such, the DCS retains overall responsibility for the components of the patient's care provided from the public mental health service.

The Collaborative Service Arrangement is not interrupted or dismantled if the patient requires admission to an inpatient service. The private psychiatrist may continue to have a collaborative role with regard to the patient's treatment during this phase of care. In particular, the private psychiatrist may work closely with the treating psychiatrist on the Unit.

If a patient makes a permanent move to another public mental health service area, the Collaborative Service Arrangement will need to be renegotiated with the relevant service. This will most appropriately occur as part of the hand over process between the public mental health services.

Instances of disagreement or conflict around the development or implementation of a collaborative arrangement should be negotiated by the relevant service providers. Staff of the public mental health service should seek advice from the DCS or delegate if they are concerned about appropriately resolving the matter.

Confidentiality requirements must be observed. Consent to disclosure of information between the service providers in the public and private sectors must be given by the patient before the Collaborative Service Arrangement can be put in place. The legal responsibility of mental health professionals within the

public mental health services is not altered by the development of a Collaborative Service Arrangement. Case managers are responsible for any clinical treatment they provide, as well as for coordinating the system of care provided to the patient within the public mental health service. Other individuals involved in the treatment of a patient are responsible for their actions and decisions in working with the patient.

A Collaborative Service Arrangement does not alter or detract from employer responsibilities. For example, WorkCover arrangements for staff of a public mental health service are not altered because they are carrying out their duties as part of a Collaborative Service Arrangement.

In the development of Collaborative Service Arrangements it is important that effective use is made of any existing professional or service network. Area based services may choose to develop specific protocols or procedures to guide the development of Collaborative Service Arrangements between providers in that area, or opt to consider proposals for a collaborative approach as they arise.

However, the following principles should guide any approach to Collaborative Service Arrangements:

- an active cooperative relationship between the two service providers is fundamental to achieving successful outcomes
- the issue of continuity of care is of primary consideration
- clear mechanisms for communication

and review are essential

- participating private psychiatrists receive appropriate recompense for their work.

CASE VIGNETTE

A private psychiatrist is concerned about the safety and well being of one of his patients—Con, a 30 year old man whom he has been treating for the past five years for a psychotic disorder and borderline personality traits. Six months ago the psychiatrist initiated a Collaborative Service Arrangement with the local Community Mental Health Service, and since that time Con has also seen a psychologist who acts as his case manager, and attends a regular support group with other young adults with similar problems.

However, Con's mental state has deteriorated significantly since the break up of a relationship some weeks ago. His psychiatrist and case manager are concerned about his increased social isolation, destructive behaviour, suicidal thinking and the re-emergence of some positive symptoms of his psychosis. Con has missed his last two appointments with his psychiatrist and is now refusing to answer the door when his case manager visits.

The private psychiatrist and the case manager discuss the situation and agree that some action is required to ensure Con's safety. They agree to involve the Crisis Assessment and Treatment service to make a further assessment of Con's condition and, if it is not possible to consider acute home treatment, to

facilitate his admission to hospital.

Con is admitted to the Acute Inpatient service linked with the Community Mental Health Service.

The Collaborative Service Arrangement is discussed with the treating team on the Inpatient Unit and it is agreed that the private psychiatrist will continue to participate in Con's treatment during this acute phase of care.

Con has a 13 day admission. During this time the private psychiatrist is in regular contact with the Unit psychiatrist and the rest of the treating team. He visits the Unit on one occasion and, with the case manager from the Community Mental Health Service, has a key role in planning for Con's discharge.

Just prior to his discharge from hospital, the private psychiatrist and case manager review the agreed management plan for Con and discuss changes with him. Con is discharged from hospital following a brief admission and with his community treatment arrangements firmly in place. The Collaborative Service Arrangement has ensured that a consistent approach to Con's care has carried through from the community to the inpatient context. In the past an inpatient admission for a patient of a private psychiatrist may have resulted in disruption to a treatment approach, and the dislocation of a therapeutic relationship.

COORDINATION

Can be Proposed by Public or Private Service Providers

STEPS TOWARDS A COLLABORATIVE SERVICE ARRANGEMENT

Typical steps to be followed by service providers in establishing a Collaborative Service Arrangement are:

Public Mental Health Service

- a referral, proposing joint service delivery, is received from a private psychiatrist
- a decision to accept a referral for collaborative service delivery is taken at the Intake stage by the relevant treatment team
- endorsement is sought from the Director of Clinical Services or delegate
- a case manager is appointed
- the case manager coordinates the development of the Collaborative Service Arrangement and the ongoing patient management with the private psychiatrist.

Private Psychiatrist

- a referral, proposing joint service delivery, is received from a public mental health service
- a decision to accept a patient for collaborative service delivery is taken
- the private psychiatrist coordinates the development of the Collaborative Service Arrangement and the ongoing patient management with the case manager.

KEY ROLES AND RESPONSIBILITIES

The key roles and responsibilities of the three principal service providers are as follow:

Private Psychiatrist

- participate with the case manager

in developing the agreed plan

- be actively involved in the ongoing management of the patient in collaboration with clinical staff of the public mental health service
- identify, with the case manager, mutually agreed contingency plans to cover the need for urgent assessment or intervention. This should include back-up plans to cover leave arrangements.

Case Manager

- participate with the private psychiatrist in developing the agreed plan
- be the central point of contact with regard to coordination of the patient's care within the public mental health service
- be actively involved in the ongoing management of the patient
- ensure input of the private psychiatrist to the Individual Service Plan
- coordinate the necessary clinical decision making in acute or crisis situations
- identify, with the private psychiatrist, mutually agreed contingency plans to cover the need for urgent assessment or intervention. This should include back-up plans to cover leave arrangements.

Director of Clinical Services

- endorse all Collaborative Service Arrangements sought by the Community Mental Health Service and ensure that appropriate recording mechanisms are in place
- ensure that on all occasions there is an appropriate use of public resources
- provide clinical leadership within the public mental health service on

issues of clinical complexity in the consideration of Collaborative Service Arrangements

- provide guidance and advice to case managers and other staff of the public mental health service where there is disagreement or conflict in the development and implementation of Collaborative Service Arrangements.

IDENTIFICATION

Of Key Roles and Communication Strategies

CASE VIGNETTE

Karen is a 38 year old woman with a diagnosis of bipolar affective disorder. She lives in a rural community, sharing a house with her older sister and her sister's family. Karen is usually shy, lacks confidence and ventures out of the house as little as possible on her own.

Although she had many admissions to hospital during her 20's, often presenting with markedly depressed mood and three times attempting suicide, her psychiatric disorder has been reasonably well controlled over the past few years. Her mood continues to become depressed from time to time, but she has been successfully treated in the community.

Once a month she will see a doctor at the nearest Community Mental Health Centre, and every two weeks she receives a visit from a social worker who monitors her mood, provides her with support, and links her in to regular day trips with a local Disability Support Service, providing welcome respite for

Karen's sister.

Karen dislikes travelling to the Community Mental Health Centre but values the support she receives from the home visits. Her sister would like to suggest that Karen see a private psychiatrist who practises closer to home, but doesn't want to lose the extra outreach assistance the social worker provides.

Karen, with the help of her sister, raises this issue with the social worker on her next home visit. As Karen's case manager, the social worker suggests to the treating team at the Community Mental Health Centre, that she contact the private psychiatrist and discuss the possibility of jointly providing a service to Karen.

After gaining Karen's agreement, the case manager contacts the private psychiatrist who is happy to consider the arrangement and makes a time to speak further on the phone—she is particularly keen to be clear about what services will continue to be available to Karen from the Community Mental Health Centre.

The ensuing phone liaison is an opportunity for the psychiatrist and case manager to clarify roles and responsibilities and develop an agreed management plan.

They agree on the following:

- the private psychiatrist will see Karen on a monthly basis. She will manage her medication and act as primary therapist
- the case manager will continue to provide an outreach service to Karen, providing support, regular assessment of her mood and an

ongoing link with the Disability Support Service

- in a situation where an urgent assessment or intervention is required, the case manager will first contact the psychiatrist and seek her involvement. If the psychiatrist is not available, the case manager will be responsible for coordinating a response drawing on whatever resources are necessary within the public mental health service, eg another psychiatrist, Crisis Assessment and Treatment service or the Inpatient Unit
- they agree to initially liaise by phone on a twice monthly basis, and to meet in six months time to review the Collaborative Service Arrangement and the management plan that is in place.

DEFINITIONS

Public Mental Health Service

General adult mental health services, usually provided on an area basis, and may include the following components:

- crisis assessment and treatment services
- mobile support and treatment services
- continuing care, clinical and consultancy services
- acute inpatient services
- residential and non-residential rehabilitation services
- secure/extended care inpatient services.

Aged person's mental health services, usually provided on an area basis, and may include:

- psychogeriatric assessment and treatment services

- acute inpatient services
- extended care inpatient services.

Child and adolescent mental health services, usually provided on an area basis, and may include:

- child and adolescent assessment and treatment services inpatient services.

Private Psychiatrist

Psychiatrists providing specialist mental health services in the private sector—providing mainly outpatient services from consulting rooms and/ or providing services at an inpatient level to private or general hospitals. Patients are seen by appointment, and liaison and consultation with a range of other agencies and service providers may be undertaken.

Private psychiatrists may specialise in a range of areas including infant psychiatry, child and adolescent psychiatry, adult psychiatry and psychiatry of old age.

Director of Clinical Services and Authorised Psychiatrist

A senior consultant psychiatrist who has overall responsibility, under the Mental Health Act, for clinical leadership within the public mental health service. While it is common for one psychiatrist to work to both of these roles, in some instance they may be split and carried out by two psychiatrists.

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Collaborative Service Arrangements

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