

**Primary Care Partnerships Service Coordination Strategy:
Guidelines for Area Mental Health Services**

**Primary Care Partnerships Service Coordination Strategy:
Guidelines for Area Mental Health Services
Mental Health Branch, March 2005**

Contents

SUMMARY	3
1 BACKGROUND	4
1.1 About primary care partnerships	4
1.2 Requirements for mental health participation in PCP service coordination	4
2 DEVELOPING PROTOCOLS WITH PRIMARY CARE PARTNERSHIP AGENCIES	5
2.1 What should the ‘protocol’ consist of?	5
2.2 Information for PCP agencies wishing to refer clients to area mental health services	6
2.3 Ongoing relationships with PCPs	7
3 THE SERVICE COORDINATION TOOL TEMPLATES	8
3.1 Referring clients using service coordination tool templates	8
3.2 Implementing secure electronic referral	10
3.3 Receiving referrals from other agencies	10
3.4 Other PCP service coordination activities	11
3.5 Privacy and confidentiality	11
4 THE FUTURE OF SERVICE COORDINATION	12
4.1 Review of the service coordination tool templates	12
4.2 Technological advances	12
5 FURTHER ADVICE AND ASSISTANCE	12
APPENDIX A: PRIMARY CARE PARTNERSHIPS AND CONTACT OFFICERS	13
APPENDIX B: SAMPLE TEXT TO ASSIST IN PROTOCOL DEVELOPMENT	15
APPENDIX C: SCTT REQUIREMENTS WHEN REFERRING CLIENTS TO PCP SERVICES	20

Summary

In 2004, the Minister for Health released a statement on the future of Primary Care Partnerships, and the need for involvement of a wider range of DHS-funded agencies in the PCP strategy. Specifically, the *Primary care partnerships strategic directions, 2004–06* states that all Department of Human Services programs will implement the PCP statewide coordination tool templates (SCTT), where relevant.

For area mental health services (AMHS), the current commitments relating to PCP service coordination are as follows:

Requirement	Timeline
Area mental health services will participate in the PCP service coordination strategy by developing standard protocols with their local PCPs regarding referral processes, including use of the service coordination tool templates.	31 December 2005
Area mental health service will implement a system for sending secure e-referrals using the SCTT, and undertake necessary liaison with internal and external stakeholders to ensure appropriate referral practice	30 June 2006*
Mental health specifications for HealthSmart patient administration systems will be developed to use this initiative as the vehicle for area mental health services to have the capacity to receive e-referrals using SCTT. Currently, implementation of HealthSmart technology in mental health services is scheduled for 2007.	HealthSmart specifications prepared by 30 June 2005

*Note that the original advice provided in the *Mental Health Triage Program Management Circular* gave this timeline as 30 June 2005. Following discussion with many services, the timeline for electronic SCTT referral has been extended by 12 months. However, mental health services should adopt the SCTT as soon as practicable during 2005 when making mail and fax referrals to agencies that use the SCTT as their preferred referral format.

This paper gives detailed advice to AMHS regarding implementation of the above requirements, and provides information resources to assist in this process. The paper outlines minimum requirements for engagement with PCPs and use of the SCTT for referrals between mental health services and other participating agencies. The paper also describes how some services have already gone beyond these minimum requirements and are actively participating in formal shared care and coordinated care activities involving PCPs. All mental health services are encouraged to become members of their local PCP(s), and to participate in initiatives that will lead to improved coordination of care for mental health clients.

Note that area mental health services have not yet been mandated to receive referrals using the SCTT and may continue with their existing arrangements for receiving referrals from other agencies. It is likely that the requirement for AMHS to receive SCTT via electronic means will coincide with the implementation of 'Healthsmart', a broad information and communication technology (ICT) system that will be implemented in mental health services in 2007.

The Department of Human Services' investment in new information and communication technologies, including Healthsmart, will provide the vehicle for a wide range of DHS-funded services to use the SCTT for referrals and for other care coordination purposes.

A DHS review of the tool templates and associated guidelines, beginning in mid-2005, provides an opportunity for mental health input into the design and content of the SCTT. A fact sheet on the review is provided with these guidelines.

1 Background

The need for mental health services to form linkages with other local health and community services was a key part of the original service model articulated in the 1990s 'framework' documents (see *Victoria's mental health services: improved access through coordinated client care*, 1995). These themes have been reiterated in a range of more recent documents. For example, the Mental Health Branch's recent program management circular on triage in area mental health services (AMHS) emphasises:

- Provision of information to other services on AMHS entry processes and eligibility criteria.
- The role of triage clinicians in providing advice and consultation to primary care providers.
- Appropriate referral of triage contacts assessed as not requiring specialist mental health services.

Given the complexity of their needs, people with serious mental illness are likely to require a range of non-mental health services. Examples include leisure activities, alcohol and drug treatment, and family/parenting support. Therefore, coordination with other health and community services may be required at all points in the clinical pathway, including case management and discharge.

Victoria's primary care partnerships offer an established and convenient mechanism through which mental health services can build stronger links with the wider service system. As described in this paper, mental health services are being asked to participate in specific activities of the primary care partnership initiative.

1.1 About primary care partnerships

Primary care partnerships (PCPs) are voluntary alliances of funded agencies. They have a diverse range of members, including major primary health care providers such as local government; home and community care; divisions of general practice; and community health. Many PCPs also include, or have established referral relationships with, disability, housing, and/or acute health services.

There are now 31 PCPs operating across Victoria (see Appendix A). Members of the PCP retain their organisational autonomy, while agreeing to common processes, protocols and systems aimed at improving service coordination and making it easier for consumers to navigate local health and community services.

1.2 Requirements for mental health participation in PCP service coordination

In 2002, the Director, Mental Health Branch wrote to all area mental health service providers about the Department of Human Services' Primary Care Partnership (PCP) strategy, and provided the PCP service coordination tool template guidelines and the PCP Privacy Resource Kit. At that stage, specialist mental health services were not required to use the tool templates, but they were encouraged to do so if this was appropriate for the individual service, or where mental health services and primary care agencies were participating in shared/coordinated care for particular clients.

In 2004, the Minister for Health released a statement on the future of Primary Care Partnerships, and the need for involvement of a wider range of DHS-funded agencies in the PCP strategy. Specifically, the *Primary care partnerships strategic directions, 2004–06* (page 2) states that all Department of Human Services programs will implement the PCP statewide coordination tool templates (SCTT), where relevant.

The requirements regarding use of the SCTT for making referrals to and receiving referrals from other participating agencies will be introduced in a staged way. For area mental health services, the current commitments are as follows:

Table 1: Mental health participation in PCP service coordination

Requirement	Timeline
Area mental health services will participate in the PCP service coordination strategy by developing standard protocols with their local PCPs regarding referral processes, including use of the service coordination tool templates.	31 December 2005
Area mental health service will have implemented a system for sending secure e-referrals using the SCTT, and undertaken necessary liaison with internal and external stakeholders to ensure appropriate referral practice	30 June 2006 ¹
Mental health specifications for HealthSmart patient administration systems will be developed to use this initiative as the vehicle for area mental health services to have the capacity to receive e-referrals using SCTT. Currently, implementation of HealthSmart technology in mental health services is scheduled for 2007.	HealthSmart specifications prepared by 30 June 2005

2 Developing protocols with primary care partnership agencies

The requirement that mental health services develop a protocol with their local PCP is based on the need for relationships between services, and a shared understanding of roles, responsibilities and ways of operating.

Protocols should be developed on the basis of adult mental health service catchment boundaries. The manager of the adult service is responsible for ensuring the development of a protocol that covers all clinical adult, aged persons and child/adolescent mental health services in the area. Where aged persons or child/adolescent mental health service catchments span two or more adult mental health services, the managers of the respective services will need to ensure that the multiple protocols are consistent with each other.

Appendix A provides a list of primary care partnerships and contact officers, and shows the relationship between PCPs and area mental health services across the State. There are 21 area mental health services and 31 PCPs, and area boundaries do not always align exactly. Except in the Inner Urban East AMHS, metropolitan area mental health services align fairly neatly with just one PCP. However, most rural AMHS cover two or more PCPS. These services will normally develop a relationship with each of the PCPs in their catchments.

2.1 What should the 'protocol' consist of?

Nearly all PCPs have already developed a document describing relationships and referral practices between member agencies. These are known as Practices, Protocols, Processes and Systems (PPPS) agreements.² The PPPS agreements describe general mechanisms through which services will deal with clients they have in common: it is not envisaged that existing PPPS agreements will change as a result of the involvement of area mental health services as members/referral partners.

The mental health 'protocol' will simply establish a clear basis for referrals and any other shared activities between mental health services and primary care partnerships. The 'protocol' does not need to be a single document, but requires mental health services to:

- 1. Develop information for PCP agencies wishing to refer clients to AMHS.**
- 2. Consult with PCPs regarding their PPPS agreements. Mental health services are encouraged to sign up to these agreements.**
- 3. Identify the major PCP 'referral partners' relevant to each AMHS component, and consult with them regarding any specific targeting and referral requirements.**

¹ Note extension of timeline from original advice provided in *Mental Health Triage Program Management Circular*, Mental Health Branch January 2004. However, mental health services should adopt the SCTT as soon as practicable during 2005 when making mail and fax referrals to agencies that use the SCTT as their preferred referral format. (see page 8).

² Most DHS regions are in the process of developing a regional PPPS document.

2.2 Information for PCP agencies wishing to refer clients to area mental health services

Information about the services offered with the AMHS should include advice about:

- The role and targeting of specialist mental health services, including differences between primary and specialist mental health care.
- Indicators for referral to the various AMHS programs.
- Processes for making urgent and non-urgent referrals.
- What to expect from mental health services, including the role of mental health services in providing advice/secondary consultation to primary care providers.

As well as providing this type of general information, mental health services should provide feedback to other agencies in relation to particular referrals, such as advice about referral outcomes, new or changed consumer information, planned service interventions, or discharge information. This not only assists the referrer in better understanding the individual's needs, but is a powerful way of educating local referrers about mental health services.

While the information about services offered and contact details will vary between AMHS, there will also be considerable commonality. Appendix B provides sample text to assist in the development of the protocols. Mental health service providers are under no obligation to use this, however, especially if they have already developed information that conveys a similar meaning. Case example 1, below, shows how one AMHS has approached the development of information for local primary care providers.

Case example 1: Mid-West Area Mental Health Service referral guide

The mid-west area mental health service has produced a detailed referral guide titled 'Information for primary care providers wanting to access mental health services.' This was an outcome of a 'needs analysis' with primary care providers in 2002, which identified a need for clear referral pathways to the many different mental health services in the mid-west catchment. The referral guide includes:

- Guidelines for referrers.
- Details of the catchment area.
- Service inclusion criteria.
- Service entry flowcharts relating to services for the various age groups:
- Information on specialist and statewide services.
- Client information (for primary care agencies to provide to clients referred for an initial (intake) assessment by specialist mental health services).
- A booklet (titled TIPS, The Information on Psychiatric Services) to assist primary care providers provide their clients with general information on mental health services.

The guide has been designed to make it readily adaptable by other AMHS, and the AMHS management is happy for other mental health service providers to adapt the guide for their own areas. The document is available at:

http://www.mh.org.au/MentalHealth/MidWest%20PMHT/Referrer_Info.htm

Information for agencies wanting to refer clients to AMHS may be provided through the following mechanisms:

- Direct provision of information to major referral partners.
- Specific protocols or memoranda of understanding between mental health services and major referral partners.
- Internet based service directories, such as local PCP service directories (e.g. ConnectingCare and Infoexchange) and the Human Services Directory.

- PCP practitioner fora.
- Informal referral feedback to the referring practitioner (particularly when the referral is inappropriate).

2.3 Ongoing relationships with PCPs

Area mental health services are encouraged to become members of their local PCPs. It should be noted that most health services that provide mental health services have joined PCPs, including:

- Barwon Health
- South West Healthcare
- Eastern Health
- St Vincents
- LaTrobe Regional Hospitals
- Ballarat Health Services
- Goulburn Valley Health
- North East Health Wangaratta
- Wodonga Regional Health service
- Mildura Base Hospital
- Bendigo Health Care Group
- Melbourne Health
- Northern Health
- Western Health
- Austin Health
- St Vincents
- Southern Health
- Bayside Health (incl the Alfred)
- Peninsula Health.

Many acute health services work with all PCPs in their catchment but have membership with only one or two PCPs. Divisions of General Practice are also represented on many PCPs, and the PCP service coordination tool templates (see Section 3) have been built into the Medical Director software used by more than eighty percent of GPs.

Although dedicated resources through PCPs are limited, the following support is available to member agencies:

- Access to locally agreed protocols and associated information resources.
- Involvement in review and redevelopment of local protocols.
- Involvement in service coordination practitioner reference groups.
- Involvement in local workforce development activities.
- Participation in local electronic referral initiatives (e.g. Connecting Care).

In some areas, active mental health involvement in PCPs has helped to attract government funding for joint initiatives involving specialist mental health and primary care agencies.

Whether or not they become formal PCP members, as a major 'referral partner' in the local health and community service network, mental health services are required to develop linkages with PCPs. The development of an ongoing relationship is necessary to ensure that the mental health-PCP 'protocol' is reflected in the day-to-day practice of mental health staff and practitioners in PCP member agencies.

There are many examples across the State of committees, working parties and other governance arrangements that include joint mental health/PCP representation. Case example 2, below, shows some of the relationships that exist in the Loddon Mallee area between the Bendigo Health Care Group, which delivers mental health services, and the PCPs in the area. There are also many other projects in the area, such as the Mental Health Triage Redevelopment Project, that involve mental health services working in collaboration with the primary care sector.

Case example 2: Mental and PCPs links in Loddon Mallee

PCP representatives on Bendigo Health Care Groups:

- Community Mental Health Governance Group
- Eating Disorders Project Reference Groups
- Community Consultative Committee on Mental Health
- Dual Diagnosis Reference Group

Bendigo Health Care Group representatives on PCPs:

- Bendigo Loddon PCP Executive (and service coordination subcommittee)
- Effective Follow-up of Suicidal and Deliberately Self harming Clients of Hospital EDs Project (with the Mildura Mental Health Service). This has resulted in agreed regional pathways and protocols, related resources (such as a chart of entry points to psychosocial services) and training for ED staff.

3 The service coordination tool templates

Sharing of client information between services, subject to appropriate privacy and consent considerations, is key aspect of the PCP service coordination strategy. Information sharing is facilitated by the use of consistent templates for providing information—the service coordination tool templates. The tools are described in Appendix C.³

The benefits of this approach are follows:

- People who use more than one local health or community service can develop a service history that is accessible to all services: new assessments build on previously collected information rather than requiring consumers to continually repeat their stories.
- Health practitioners have a single referral form for all community services, and do not have to spend time sourcing different forms for different services.
- Consumers are more likely to get the right service at the right time because referrals are streamlined and there are mechanisms (such as feedback on individual referrals) to strengthen practitioners' understanding of other health and community services.

Greater benefits of the SCTT are realised when they can be shared electronically, and using compatible data and information standards. This means that basic client data has to be entered only once, and automatically 'populates' to the receiving agency's database when a referral is made. Therefore, service providers can spend less time on basic administration and more time on actual service delivery.

3.1 Referring clients using service coordination tool templates

A referral occurs when one agency requests another agency to provide an assessment or service to a client: this usually involves the transmission of an individual's personal, health or care information from the referrer to the agency receiving the referral.

³ AMHS will receive a folder containing the current set of service coordination tool templates and associated guidelines. This information is also available electronically at www.health.vic.gov.au/pcps

Consistent with previous advice from the Mental Health Branch, mental health services are encouraged to facilitate referrals to other community based services where this is likely to be of benefit to the client. Referrals to primary care and related services may be appropriate for current consumers requiring supplementary care, for consumers being discharged from the mental health service, and for people assessed at triage or intake as not requiring a specialist level of mental health treatment.

Mental health services already make many referrals to a range of health and community services. Currently, this requires mental health clinicians to source and complete one of range of different referral forms. The SCTT replaces a range of different forms with a single referral format. To date, the SCTT have replaced over 350 different referral forms; in the future, an even wider range of DHS-funded will be using the SCTT for referral and information exchange.

3.1.1 What information should be included in a SCTT referral?

The requirement to use the SCTT template for referrals to primary care agencies (and other agencies participating in the PCP strategy) will not necessarily affect the type of referrals made by mental health services or the nature of the referral information provided. Decisions about whether to refer a client to another service and, if so, what information to provide with the referral, will remain issues of professional judgement.

As described further in Appendix C only two of the five SCTT components will normally be used when making a referral to a PCP (or other participating) agency:

- The Consumer Information Template
- The Summary and Referral Template.

There is no requirement to complete all data fields of either of the above templates, as discussed below. Additional information (such as a letter from a psychiatrist or the results of an assessment) can be attached to the SCTT referral in any format—subject to privacy, consent and electronic security provisos.

Consumer Information Template: Many of the fields on the Consumer Information Template collect the same type of information as required by RAPID and existing AMHS' triage contact forms. This includes basic demographic data such as name, address, date of birth, country of birth, sex, indigenous status, and preferred language and key service information such as 'need for an interpreter'. Clearly, mental health services should provide this type of information, unless there are specific reasons for not being able to do so. Further fields on the Consumer Information Template should be completed in accordance with good practice and the mental health worker's knowledge of the receiving service. For example, data items should be provided:

- Where the 'referred to' agency needs a particular type of information in order to decide whether or not to accept the referral.
- Where the information is likely to be helpful to the 'referred to' the agency, and this is available to the mental health worker or readily obtainable.

The level to which the Consumer Information Template is completed will vary depending on the circumstances in which the referral occurs. For example, mental health triage clinicians referring to other services may have only minimal demographic information about the client, whereas a caseworker is likely to have a lot of information.

Summary and Referral Template: The Summary and Referral Template is the SCTT section in which referrers provide their professional observations about the client and his/or her needs for service provision: this is usually the most important part of the referral. Although brief information about the reason for referral can be included in the 'notes' field of the Consumer Information Template, it is preferable to use the Summary and Referral Template for this purpose. The separation of basic client data (i.e. the Consumer Information Template) from qualitative information about a particular referral is an important aspect of the service coordination strategy because it allows the Consumer Information Template to be shared between multiple services, while specific and/or sensitive information can be retained by only those services that need it.

3.1.2 When should we start using the SCTT?

Mental health services are not required to implement *electronic* SCTT referrals to PCP agencies until June 2006. However, it is good business practice to make referrals in a way that is acceptable to the agency receiving the referral. Therefore, mental health services should adopt the SCTT as soon as practicable when making referrals to agencies that use the SCTT as their preferred referral format. The use of the SCTT for outward-going referrals should definitely be in place by the end of 2005. However, where the mental health service does not have the capacity for secure electronic transfer of the SCTT (prior to 30 June 2006), SCTT referrals can be sent via mail or fax.

3.2 Implementing secure electronic referral

There are currently no plans to develop SCTT-compliant interface software for the RAPID/CMI system. Therefore, pending the implementation of Healthsmart in 2007, AMHS will need to develop interim mechanisms for generating and electronically transferring the SCTT.

In most cases, the most straightforward option for mental health services will be to use their local PCP's existing internet-based referral system to generate and send referrals to other agencies.⁴ Two main referral systems have implemented the SCTT as interactive web pages. These are:

- *ConnectingCare*, originally developed by the Northern Mallee PCP and now used in more than half the PCPs across the State (go to www.connectingcare.com for details).
- *Infoexchange*, originally developed by the Outer East Health and Community Service. A number of other PCPs across the State are using variations of this system

One advantage of these systems is that they have in-built mechanisms for ensuring the security of data transferred via the SCTT. (Although any mental health services planning to *receive* electronic referrals via *ConnectingCare* will need to install special software called Public Key Infrastructure (PKI) to be able to 'translate' the encrypted data it receives).

Mental health services should consult with their local PCP to identify the most appropriate technological solution for secure electronic transfer of the SCTT. Note, however, that the capacity for e-referrals are more advanced in some areas than others. Initiatives undertaken during 2005 should improve the availability, utility and consistency of PCP electronic referrals systems across the State.

Note also:

- Where particular PCP agencies are not yet *accepting* electronic referrals using the SCTT, mental health should send the SCTT via mail or fax.
- Until Healthsmart is implemented, referral information will usually need to be manually entered (or copied and pasted from agency's client software application) into the SCTT. However, some area mental health services have developed technology that allows for the SCTT Consumer Information Template to be 'autopopulated' with consumer data extracted from an existing database. Services that are interested in exploring this potential should contact the Mental Health Branch for specific advice (see Section 5).

3.3 Receiving referrals from other agencies

Area mental health services have not yet been mandated to receive referrals using the SCTT and may continue with their existing arrangements for receiving referrals from other agencies. It is likely that the requirement for AMHS to receive SCTT via electronic means will coincide with the implementation of 'Healthsmart', a broad information and communication technology (ICT) system that will be implemented in mental health services in 2007.

⁴ It is also possible for mental health services to simply send SCTT referrals (in Microsoft Word format, for example) using a standard email system, provided it has installed software to ensure the security of consumer data transferred to other agencies.

Once this occurs, the SCTT will be included in the software application used by mental health services, enabling them to receive referrals electronically and import referral information directly into the patient administration system. This will create the efficiencies that are intended by the PCP service coordination strategy, in that mental health workers will not have to re-enter client data that has already been collected by other agencies.

As well as ensuring a smooth transition in the technical aspects of handling electronic referrals, delaying the requirement to receive electronic SCTT referrals will give mental health services the opportunity to implement any change management within mental health services that is necessary to ensure efficient and consistent assessment of referrals.

3.4 Other PCP service coordination activities

As noted earlier, area mental health services are required to use only those components of the SCTT that are necessary for referring clients to PCP and other participating agencies.

However, mental health services are encouraged to participate in coordinated/shared care arrangements with PCP agencies where this helps improve outcomes for individual clients and is consistent with privacy/consent requirements. As illustrated in Case example 3 some mental health services are already participating in formal shared care arrangements with local primary care practitioners, using the SCTT and/or other common information management tools.

The forthcoming review of the SCTT (see Section 4) provides an opportunity for mental health input to the tool templates, thereby improving the usefulness of the Supplementary Profiles and Service Coordination Plan for shared/coordinated care arrangements involving mental health consumers.

Case example 3: Care coordination between Barwon Area Mental Health Service and local primary care services

Technology-based service coordination initiatives are well advanced in this area, assisted by mental health, community health and drug treatment services being part of the same organisation (Barwon Health) and having a common IT infrastructure. A number of local general practitioners are also involved in electronic service coordination arrangements, and have the capacity—through their Medical Director software—to generate and receive SCTT referrals, and to receive electronic discharge summaries from Geelong Hospital.

Barwon AMHS has developed shared care plans with primary care agencies, particular GPs and Pathways (the local PDRSS), for approximately 600 of its consumers. A common care-planning template, aligned with SCTT Service Coordination Plan, is being trialed. Some parts of the template must be completed by all service providers involved, while other parts allow providers to record information that is specific to their own agency. Participating agencies can impose electronic 'filters' so that only certain information can be viewed by other agencies.

3.5 Privacy and confidentiality

As part of the PCP service coordination strategy, agencies share consumers' personal information in a way that meets privacy requirements and supports consumers' healthcare needs. PCP privacy and confidentiality provisions are discussed in Guideline 5 of the Service Coordination Tool Templates. For further information on privacy policy and legislation go to www.dhs.vic.gov.au/privacy

The one-page Consumer Consent Form in the SCTT provides a uniform approach to obtaining consumer consent in a way that is consistent with the *Health Records Act 2001*. Responsibility for obtaining consumers' consent to provide their information to other services rests with the referring professional, with the decision about whether to obtain written consent—as opposed to verbal consent—considered a matter for professional judgement. The Consent Form is not intended to be shared with other services, but is retained by the provider who collects the information. (Information about whether or not consent was obtained is recorded on the Summary and Referral Form).

At this stage, area mental health services are not required to use the SCTT Consumer Consent Form, and may continue with current processes for recording consumers' consent to share their personal details outside the AMHS. The forthcoming review of the tool templates and associated guidelines (see Section 4.1) provides an opportunity for privacy and consent issues relating to mental health consumers to be taken into account in the PCP service coordination strategy.

Mental health clinicians and other key workers should be mindful that the basis for decisions about disclosing information remains Section 120A of the *Mental Health Act 1986*. When making a referral to a primary care agency, the mental health professional would normally discuss any referral with the consumer and obtain at least verbal consent to the disclosure of his or her personal information to other services. 'The best interests of the client' should be the overriding principle in the decision about whether to make a referral, and what information to share with other agencies. Information should be provided to other agencies strictly on a 'need to know' basis and where this will facilitate improved consumer care.

4 The future of service coordination

4.1 Review of the service coordination tool templates

The service coordination tool templates will increasingly be used for referrals between a wide range of DHS funded services, and therefore it is important they are appropriate for mental health services, both in receiving and making referrals.

A DHS review of the tool templates and associated guidelines, beginning in mid-2005, provides an opportunity for mental health input into the design and content of the SCTT. A fact sheet on the review is provided with these guidelines. Service providers are encouraged to contact Deirdre Pinto (contact details below) before 30 May 2004 to provide feedback on the SCTT.

4.2 Technological advances

The development of messaging standards for the SCTT, and the Department of Human Services' \$30 million investment in new information and communication technologies, will provide the vehicle for a wide range of DHS-funded services to use the tool templates for referrals and for other care coordination purposes. The SCTT and associated data specifications are being built into major ICT platforms including Healthsmart (covering acute hospitals, community health services and a range of other primary care providers, as well as area mental health services) and the Client Referral and Information System (to be used by child protection, family support, drug treatment, and disability services).

5 Further advice and assistance

Appendix A provides a list of PCP contact officers/managers and also lists the DHS regional officers who are responsible for primary care partnerships. Further sources of information are:

- Deirdre Pinto of the **Mental Health Branch** (Tel: 03 9616-8548; email: deirdre.pinto@dhs.vic.gov.au), who can provide general advice on the implementation of mental health PCP requirements, and can act as a contact point for accessing more technical advice from the DHS Service Coordination Team.
- The mental health contact officer in each DHS Region, who is available to provide support and assistance to mental health services.
- A self-paced training program on the SCTT currently being developed by DHS. The internet-based program is expected to be available by mid-2005.
- The website for general information about the PCP strategy—<http://www.health.vic.gov.au/pcps/index.htm>

Appendix A: Primary care partnerships and contact officers

Primary Care Partnership	PCP Contact Officer	PCP Local Government Areas	'Best Fit' AMHS ⁵
Boroondara Central East	Jonathon Pietch, PCP Manager (t) 9262 6593 (e) jonathon.pietch@whitehorse.vic.gov.au	Booroondara	Inner Urban East
		Monash Whitehorse Manningham	Central East
Outer East Health and Community Support Alliance	Ms Janette Mitchell, PCP Manager (t) 9298 4584 (e) janette.mitchell@maroondah.vic.gov.au	Maroondah Knox Yarra Ranges	Outer East
Banyule-Nilumbik	Ms Bronwyn Fleming, Project Manager (t) 9457 9845 (e) bronwyn.fleming@banyule.vic.gov.au	Banyule Nilumbik	North East
Hume-Moreland	Ms Fiona Lynch, PCP Project Manager (t) 9300 3082 (e) flynch@moreland.vic.gov.au	Hume Moreland	North West
North Central Metropolitan	Ms Bernadette Burchell, Executive Officer (t) 9480 3044 (e) bburchell@ncmpcp.org.au	Whittlesea Darebin Yarra	Northern Inner Urban East
Brimbank-Melton	Mr Bruce Watson, PCP Project Manager (t) 9361 9300 (e) brucew@djhs.org.au	Brimbank Melton	Mid West
Moonee Valley-Melbourne	Ms Dianne Couch, Executive Officer/Manager (t) 8325 1855 (e) dcouch@mvcc.vic.gov.au	Moonee Valley Melbourne	Inner West
West Bay	Ms Lee Kennedy, PCP Alliance Manager (t) 9398 0718 (e) wpcphp@gwhealth.asn.au	Wyndham Hobson's Bay Maribyrnong	South West (Werribee Mercy)
Inner South East Partnership In Community Health	Mr Barry Hahn, PCP Project Manager (t) 9209 6455 (e) bhahn@portphillip.vic.gov.au	Port Phillip Stonnington Glen Eira	Inner South East
Kingston-Bayside	Mr Terry Lazzarotto, PCP Project Manager (t) 8587 0317 (e) tlazzarotto@cbchs.org.au	Kingston Bayside	Middle South
South East	Ms Wendy Mason, PCP Project Manager (t) 8792 2266 (e) wendy.mason@southernhealth.org.au	Greater Dandenong Casey Cardinia	Dandenong
Frankston-Mornington Peninsula	Ms Dianna Mumme, Executive Officer (t) 9784 8304 (e) dmumme@phcn.vic.gov.au	Frankston Mornington Peninsula	Peninsula
Barwon Primary Care Forum	Ms Sandy Austin, PCP Project Manager (t) 5224 2385 (e) Bronwyn.fleming@banyule.vic.gov.au	Colac-Otway Greater Geelong Queenscliffe Surf Coast	Barwon
South West	Mr Craig Fraser, PCP Project Manager (t) 5563 1244 (e) cfraser@swarh.vic.gov.au	Corangamite Moyne Warrnambool	Glenelg (South West)
South Grampians-Glenelg	Ms Rosie Rowe, PCP Executive Officer (t) 5551 8471 (e) rosie.rowe@smppcp.org	Southern Grampians Glenelg	Glenelg (South West)
Central West Gippsland	Ms Meredith Davey, Project Manager (t) Meredith.davey@lchs.com.au	Latrobe Baw Baw	Gippsland

⁵ Boundaries do not always align. (e.g. Barwon AMHS also covers part of the area covered by South West PCP (Corangamite South) and part of the area covered by Central Highlands PCP (Golden Plains).

Primary Care Partnerships Service Coordination Strategy: Guidelines for Area Mental Health Services

East Gippsland	Mr Peter Muldoon, Executive Officer (t) 5153 1146 (e) peterm@lech.org.au	East Gippsland	Gippsland
South Coast Health Services Consortium	Mr Kirk Warren, PCP Executive Officer (t) 5674 3105 (e) k.warren@sggp.com.au	Bass Coast South Gippsland	Gippsland
Wellington	Ms Jodie Pullman, Health Promotion Coordinator (t) 5143 1600 (e) wpcphp@gwhealth.asn.au	Wellington	Gippsland
Central Highlands	Ms Tracey Wilson, PCP Policy & Development Officer (t) 5336 3844 (e) chpcp@netconnect.com.au	Ballarat Golden Plains Moorabool Hepburn	Grampians
Grampians Pyrenees	Ms Kate Serrurier, Executive Officer (t) 5349 1300 (e) n/a	Ararat Northern Grampians Pyrenees	Grampians
Wimmera	Ms Bernadette Hetherington, PCP Coordinator (t) 5382 7660 (e) bernieh@wimmera.unitingcare.org.au	West Wimmera Hindmarsh Yarriambiack Horsham	Grampians
Central Hume	Mr Lyndon Seys, PCP Chair (t) 5751 9300 (e) lyndon.seys@alpine.hume.org.au	Alpine Delatite Wangaratta	North East Hume
Upper Hume	Ms Judith Moore, PCP Project Manager (t) 02 6055 9284 (e) jmoore@wodonga.vic.gov.au	Indigo Towong Wodonga	North East Hume
Goulburn Valley	Mr Neil Stott, PCP Project Manager (t) 5862 2681 (e) gvpcp@gvchs.com.au	Moira Strathbogie Greater Shepparton	Goulburn
Lower Hume	Ms Yvonne Padgett, Community Development Worker (t) 5797 3271 (e) lowerhumepcp@virtual.net.au	Mitchell Murrindini	Goulburn
Bendigo Loddon	Ms Carolyn Wallace, Executive Officer (t) 5434 4362 (e) carolynwallace@bchs.com.au	Bendigo Loddon	Loddon Campaspe/Southern Mallee
Campaspe	Ms Emma Bretnall, Team Leader (t) 5484 3299 (e) ebpcp@origin.net.au	Campaspe	Loddon Campaspe/Southern Mallee
Central Victorian Health Alliance	Ms Lisa Delaney, Executive Officer (t) 5472 5333 (e) ldelaney@netcon.net.au	Mt Alexander Central Goldfields Macedon Ranges	Loddon Campaspe/Southern Mallee
Southern Mallee	Ms Linda Kelly, Executive Officer (t) 5032 4479 (e) manager@smpcp.org	Swan Hill (Excl. Statistical Local Area of Robinvale)	Loddon Campaspe/Southern Mallee
Northern Mallee	Ms Christine Dinale, PCP Administration Officer (t) 5021 4875 (e) nmpcp@ncable.com.au	Mildura (Incl. Statistical Local Area of Robinvale)	Northern Mallee

Regional contact officers for primary care partnerships:

- Barwon South Western: Toni Clarke, 03 5226-4711
- Eastern Metropolitan: Kate Paterson, 03 9843-6244
- Gippsland: Tim Owen, 03 51772557
- Grampians: Barry Robbins, 03 5333-6083
- Hume: Neil Duggan, 03 5722-0906
- Loddon Mallee: Paul Sherman, 03 5434-5507
- North & West Metropolitan: Clare Carberry, 03 9412-5416
- Southern Metropolitan: Carolyn Marshall, 03 8710-2814

Appendix B: Sample text to assist in protocol development

In addition to the general information below, the protocol should:

- **Include details of the catchment area for the adult, child/adolescent and aged persons services, and should include a description of various service components within these programs⁶**
- **Clearly describe referral pathways and initial contact (triage) points for each main service type. The AMHS's 24/7 contact number should be provided, in addition to any separate business hours numbers for particular services.**
- **Specify whether triage points accept referrals via fax, email or other electronic means, and circumstances in which a telephone call from the referrer is also required.**

1. About the public specialist mental health system

Public specialist mental health services include both clinical and psychiatric disability rehabilitation and support services.

Clinical mental health services provide assessment, diagnosis, and treatment to people with a serious mental illness. Clinical mental health services are organised and delivered on an area basis, with a defined catchment area known as an area mental health service. Each area mental health service provides a range of specific services to people who live in the catchment area. This is somewhat different from the organisation of general medical services, for which people can present at a hospital or service of their choice.

Clinical services are delivered under three main programs—child and adolescent (0–18 years), adult (16–64 years) and aged persons (65 years or older)—reflecting the different needs of people across the lifespan. Since 1995, major health services have managed and provided clinical mental health services. Most mental health care is provided in the community, rather than in hospital settings.

Psychiatric disability rehabilitation and support services (PDRSS) form the second important part of the specialist mental health service sector. These services, sometimes referred to as the 'non-clinical' specialist mental health sector, play a key role in supporting consumers and carers throughout the recovery process, focusing particularly on the needs of those people with enduring and serious mental illness. Psychiatric rehabilitation and disability support services are provided by non-government community organisations.

There are also several statewide services, including specialised mother and baby units, eating disorders units and neuropsychiatry units.

2. Role and targeting of the specialist mental health sector

Specialist mental health services are aimed primarily at people with more severe forms of mental illness or disorder, whose level of disturbance or impairment prevents other services from adequately treating or managing them.

There are many other service providers, in both the public and private sectors, able to deal with people with less serious mental health problems or illnesses. These include general practitioners, counsellors, private psychiatrists and psychologists, support agencies, non-government services and self-help groups, among others.

⁶ Mental health services may wish to supplement/adapt the service information provided in the 'Further information' section of the MHB document *Welcome to mental health: your guide to Victoria's specialist clinical services*, www.dhs.vic.gov.au/mentalhealth

3. Indicators for referral to specialist mental health services

The following indicators are intended to assist service providers in determining whether a person appears to have a mental illness or disorder, and whether specialist mental health assessment is warranted. The indicators should be seen as a guide rather than as factors confirming the presence of a serious mental illness or disorder. Mental state assessment is the responsibility of mental health clinicians.

Adult and aged mental health services

In general, adults who have a serious mental illness or disorder will exhibit a significant disturbance in thought, mood or behaviour. They may also experience disturbances in perception or memory. Specific symptoms and signs will vary depending on the mental disorder and the person's age, but a person may have a mental illness or disorder if they are exhibiting any of the following symptoms, and these symptoms do not appear to be primarily caused by injury, physical illness or drug/alcohol intoxication:

- bizarre or unusual thinking
- hallucinations (seeing, hearing or feeling things that are not really there)
- significant changes of mood, such as pronounced depression, pronounced anxiety or pronounced elevation in mood
- restless, agitated and disorganised behaviour or marked decrease in activity
- significant impairment of social and/or occupational functioning
- significant impairment in self-care
- suicidal thoughts or acts of self-harm
- destructive or high risk behavior
- significant memory impairment
- confusion and disorientation.

Child and adolescent mental health services

This target group includes young people with a diagnosable psychiatric disorder whose condition is seriously detrimental to their growth or development and/or who have serious difficulties in their social group or family.

Emotional disturbance in childhood and adolescence may present in a variety of ways. While symptoms may include impaired reality testing, hallucinations, depression and suicidal behaviour, emotional disturbance in childhood presents often in other ways. Hyperactivity, nightmares, fearfulness, bed-wetting, language problems, refusal to attend school, and stealing are among the behaviours that may indicate distress or disturbance. Presentations will also differ depending on the individual's age and developmental stage. Many young people manifest some of these behaviours at one time or another, but they are not considered emotionally disturbed unless they exhibit a pattern of symptoms that are inappropriate for their age, stage of development or circumstances.

Some children and adolescents are at higher risk of a serious mental disturbance. They include:

- victims of physical, sexual and/or emotional abuse
- those within the welfare and juvenile justice system
- homeless youth
- those from severely disruptive homes
- those whose parents suffer from a mental illness or a dependence on drugs or alcohol
- those with developmental difficulties, learning difficulties and/or an intellectual disability
- those with chronic health problems and disabilities
- post-trauma and post-disaster victims.

Service providers who are concerned about the mental state of a child or adolescent, especially one from a high-risk group, are encouraged to contact the child and adolescent mental health service to discuss whether it may be appropriate to make a formal referral to the service.

4. Making referrals to specialist mental health services

While the specialist mental health service system is only one part of a broader service system available to people with mental health problems, the level and nature of a client's mental health presentation may necessitate support from a specialist mental health service.

The following guidelines are suggested for primary care agencies referring to specialist mental health services:⁷

- Before making a referral, discuss the referral with your client first to ensure that you have their consent. Where there is a high level of risk to a client or others, urgent referrals to specialist mental health services can be made without the client's consent.
- Check that the client lives in the area serviced by the area mental health service you are referring them to.
- Check the 'target group' for the specific service that you wish to refer to. If you are unsure which service is most appropriate, please call our 24-hour, seven day a week contact number (INSERT TELEPHONE NUMBER).
- Check that your client's details (name, address, phone number etc) are current and correct.
- Be specific about your client's symptoms and mental status, any mental illness history or treatment that you are aware of, the risks or complexities that cannot be managed by your service, and the reasons why the referral is occurring at this point in time.
- Be as specific as you can about the purpose of the referral and type and level of service you are seeking for your client, for example, assessment and treatment, crisis management, additional support, diagnostic opinion or consultation.
- Describe the nature of the client's involvement with your services (and any other services that you know to be involved with the client).
- Note that responsibility for the client remains with the referrer until the referral is accepted by the area mental health service.

5. Urgent/crisis referrals

Where possible, contact between specialist mental health services and other service providers should preferably happen in a planned way and not only at a time of acute crisis. A benefit of collaboration in 'non-crisis' times is that, should further contact be required during a more critical episode, specialist mental health clinicians will be able to access the information obtained in previous contacts.

There will be situations, however, in which an urgent referral to specialist mental health services is required. The responsibility for responding to requests for urgent assessment and treatment rests with the area's Crisis Assessment and Treatment Service or clinician performing the CAT function. CAT services are responsible for providing urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. Typically such clients will:

- Have a known or suspected mental illness or mental disorder
- Be thought to be in the acute phase of illness or at risk of an acute episode
- Be at significant risk to themselves or others
- Be thought to require intensive assessment, treatment or support or possible hospital admission.

⁷ Adapted from 'Information for primary care providers wanting to access mental health services', Mid-West Area Mental Health Service, 2004.

To access a crisis response from the mental health service, you should telephone (**INSERT DETAILS AND CONTACT NUMBERS AS APPROPRIATE**—e.g. “the triage clinician, who will arrange access to the CAT clinicians where required”).

It is important to note that CAT services are not an emergency service in the same way as police and ambulance and may not always be able to provide an immediate response. CAT may also need the assistance of police in responding to referrals of persons in psychiatric crisis.

The client’s physical safety and the safety of others are always the first priority. Psychiatric intervention can be undertaken only once the person is medically stable, has recovered from the immediate effects of drugs or alcohol, and is in an environment where they can be managed and assessed safely. The referrer should consider the need to involve emergency services (police or ambulance) prior to requesting assistance from the mental health service.

Urgent referrals should include as much information as possible regarding the situation:

- the person’s current location
- the presenting problem, behavior or symptoms
- evidence of use of any drugs or alcohol
- evidence of risk to self and/or others
- other services and people involved
- presence or availability of family members.

Where it is decided that the CAT clinician will conduct an urgent assessment, specific arrangements will need to be negotiated with the referring service provider. These will include:

- where the assessment will be undertaken
- who will be involved
- the anticipated time of the assessment.

6. What to expect from specialist mental health services

Supplement with specific information about triage/entry point services.

All referrals to clinical mental health service components will be assessed by an appropriately skilled and qualified mental health clinician, who will conduct a preliminary screening of whether a person is likely to have a mental illness or disorder, and the nature and urgency of the response required. This process is called **mental health triage**.

The triage clinician’s role is to provide clear, relevant information and advice to clients, carers and/or services requesting assistance with mental illness issues.

Where the triage clinician considers that specialist mental services are not the most appropriate option, the client may be referred to an alternative service or given other advice. The mental health clinician conducting the triage assessment should provide feedback to the referrer on the reasons for non-acceptance of referrals.

Where the mental health triage assessment determines that the client requires specialist mental health treatment or further assessment, a range of responses may be provided including:

- Further assessment, either urgent or non-urgent.
- Short-term treatment and support in hospital or the community.
- Continuing care.

Once the client has been accepted into the specialist mental health service system, he or she will be assigned a case manager. The case manager will coordinate the client's mental health treatment and care, and will be the contact point for any client enquires. . Where appropriate, specialist mental health clinicians will work collaboratively with other services involved with the client.

7. Collaboration between specialist mental health and other services

People move in and out of the specialist mental health service system depending on need. As with serious medical conditions, some people with a mental disorder are referred for a specialist opinion or when symptoms escalate and they require specialist intervention or hospitalisation: they return to the care of their general practitioner or other clinician, or they may no longer need any treatment, when symptoms settle or they recover. Specialist mental health services will establish or maintain a client's links with other support services, so that these are available once the client's condition has stabilised or maximum recovery has occurred.

Where other services are involved in a person's care simultaneously, mental health clinicians will work in collaboration with the other providers, and may adopt shared care approaches to service provision where appropriate.

Collaboration between specialist mental health and other service providers may result in one or more of the following outcomes:

- Specialist advice on the nature and optimal management of the client's condition
- Establishment of ongoing collaborative care between the general service providers and specialist mental health staff in shared care arrangements
- Planning for future contact between services and re-accessing mental health services. For example, an early warning signs or crisis prevention/management plan might be developed, which clearly sets out the roles and responsibilities of all professionals involved with the person's care and establishes the actions that will be taken if one of a number of scenarios occurs.

8. Resolving complaints

If concerns arise in relation to any aspects of assessment or treatment by mental health services, the preferred action in the first instance is to speak directly to the staff involved, the case manager and/or the service manager. If concerns still exist, all services have formal mechanisms to address any complaints or concerns.

Insert service-specific complaint resolution procedures.

Other options include contacting the Office of Chief Psychiatrist within the Department of Human Services (Telephone: (03) 9616-7571) or the Victorian Health Services Commissioner (Telephone: (03) 8601-5222).

Appendix C: SCTT requirements when referring clients to PCP services

SCTT component	Purpose	Notes
Consumer information	<p><u>Page 1</u>: Demographic and social details of the consumer, contact person/s and GP, and how the information was obtained</p> <p><u>Page 2</u>: Source of referral, other demographic information and benefits, entitlements and insurance status</p>	<p>Basic information should be provided unless unobtainable (e.g. family and given names; address; date of birth; telephone number; 'this page completed by'; service requested; preferred language; interpreter requirements)</p> <p>Provision of additional information is a matter of professional judgment/good practice, and determined by availability and/or the 'referred to' agency's needs</p>
Summary and referral	<p><u>Page 1</u>: Summary of presenting problems and a text box to record other relevant information</p> <p><u>Page 2</u>: Services used in last three months and initial action plan.</p>	<p>Page 1 should be completed</p> <p>Completion of Page 2 will depend on circumstances of referral and availability of information</p>
Supplementary profiles		Not required
Living arrangements	Living arrangements, legal, financial and employment, carer profile	
Health conditions	Overall health, pain, vision, hearing, falls, conditions and medications	
Psychosocial profile	Mental health, wellbeing, social and family supports and disability criteria	
Functional profiles	<p><u>Page 1</u>: Activities of daily living and self-care</p> <p><u>Page 2</u>: Cognitive and behavioural problems</p>	
Health behaviours	Risk factors, nutrition and physical activity	
Service coordination plan	<p><u>Page 1</u>: key worker, review date, participants' list, case conference/date and information given to consumer</p> <p><u>Page 2</u>: Action plan for each goal</p>	Not required
Consumer consent form	<p><u>Section 1</u>: Proposed information use and disclosures</p> <p><u>Section 2</u>: Record of consumer consent (written or verbal)</p>	Not required. As part of the PCP service coordination strategy, the Consent Form is held by the referring agency. Mental health services are not mandated to use the form (see Section 3.5)