

Standard 9. Integration

The MHS collaborates with and develops partnerships within its own organisation and with other service providers to facilitate coordinated and integrated services for consumers and carers.

GUIDELINES

The intent of this standard is to ensure that mental health services (MHS) are integrated and provide continuity of care for consumers and carers at several levels, from the individual consumer level, to the person coordinating the care, the team and organisational levels, through to that involving other service providers.

Continuity and coordination of care (Criterion 9.1)

The person responsible for coordination of care helps consumers, carers and service providers to work together by facilitating links in and outside the organisation. They ensure consumers are matched with the most appropriate provider so that the consumers' transition to other levels of service in the continuum is seamless and timely and there is no duplication in assessment, service planning and delivery.

The person responsible coordinating care is identified on admission or soon after and the consumer and carer, where appropriate, should be informed that this person is responsible for:

- coordinating assessment
- coordinating treatment and support
- facilitating a smooth transition of care to other services and between case managers as required
- planning collaboratively with the consumer and carer
- communicating with the consumer and carers where appropriate regarding all aspects of care
- coordinating the interdisciplinary care team.

Support for interdisciplinary care teams (Criterion 9.2)

The MHS should schedule regular interdisciplinary care team meetings to ensure a shared focus on the consumer's care.

The MHS should audit treatment, care and recovery plans regularly during each episode of care to identify evidence of input from interdisciplinary care teams.

Members of the interdisciplinary care team contribute their particular expertise. The team should share information and work interdependently. Leadership of the interdisciplinary care team should be task-dependent with tasks defined by the individual consumer's situation. The person responsible for coordinating the consumer's care should be a member of the interdisciplinary care team and have been responsible for coordinating the activities of the interdisciplinary care team to achieve the best possible outcome for consumers.

Collaborative planning (Criterion 9.3)

The MHS should inform staff, consumers and carers about the range of health care and related services that are available.

The MHS can provide treatment and support to a consumer at several sites including inpatient, community-based rehabilitation or recovery centres or at home.

For organisations with many sites, the process of engagement with the service and / or transfer between services should be standardised and consumers need to be informed where services will be provided.

To promote integration and continuity of care between MHS programs and sites there needs to be regular team leader meetings and service wide meetings that include inpatient and community staff.

The MHS should ensure that staff are familiar with policy and procedures relating to contact with internal and external services and providers. Contacts with internal and external services and providers, including referrals, should be documented.

The MHS should have an up-to-date resource folder in hard and soft copy to inform staff, consumers and carers about the range of other health and related services.

There should be regular meetings with other service providers to maintain or establish links and partnerships that facilitate continuity of care for the consumer.

Links with primary health care providers (Criterion 9.4)

Shared care arrangements between general practitioners (GPs), private psychiatrists, non-government organisations and other relevant agencies should be used to facilitate consumer recovery.

Examples of models of shared care arrangements include:

- GPs and other mental health care providers, such as the Better Access Initiative and the Access to Allied Health Professionals (ATAPS) which aim to increase community access to mental health professionals
- Community Mental Health Case Manager, the Mental Health Intake and Assessment Team and the Acute Mental Health Unit.

When clinical supervision for the patient is transferred to the primary care provider, such as the GP, the MHS should provide feedback that will assist the GP. This feedback should contain:

- notification of discharge from hospital and what has happened to the consumer
- any change in legal status of the consumer, for example, community treatment orders (CTO) or community care orders (CCO), changes in treatment, medication, physical health or pathology results
- recommendations for the GP in the treatment of the consumer
- details of the contact person and process for re-entry to the MHS if the consumer relapses.

Interagency and intersectoral links (Criterion 9.5)

The MHS works with other service providers, including welfare services, primary care practitioners, disability support services, emergency departments, aged-care providers and transcultural and multicultural mental health agencies.

Links and partnerships with external services, such as alcohol, tobacco and other drug services (ATODS), should be supported by formal service agreements. Where there is no formal agreement the MHS should have clear procedures on how to establish and maintain contact with these services.

The MHS needs to develop links between child and adolescent, adult and older person programs and other service providers, to ensure a smooth transition to age-appropriate services as required.

Examples of partnership agreements could include links with:

- drug and alcohol services
- the youth sector
- housing providers
- employment providers

- Centrelink
- aged-care services:
 - health promotion/public health services
 - local government
 - community services
 - churches and religious groups
 - schools
 - the tertiary education sector
 - Aboriginal and Torres Strait Islander groups
 - divisions of general practice
 - multicultural groups
 - early childhood services
 - maternal and baby health services.

SUGGESTED EVIDENCE

Evidence that may be provided for this standard includes:

- audit of treatment, care and recovery plans
- evidence of team leader meetings
- discharge summaries supplied to primary health care providers
- evidence of shared care arrangements
- partnerships with other service providers, such as alcohol, drug and tobacco services
- policies and procedures covering:
 - contact with internal and external services
 - process of transfer between services
 - orientation program
 - supervision and training programs.