PMHA | PRIVATE MENTAL HEALTH ALLIANCE

# PRINCIPLES FOR COLLABORATION, COMMUNICATION AND COOPERATION BETWEEN PRIVATE MENTAL HEALTH SERVICE PROVIDERS

The *Principles for Collaboration, Communication and Cooperation between Mental Health Providers* have been officially recognised as an Accepted Clinical Resource by The Royal Australian College of General Practitioners. The Private Mental Health Consumer Carer Network (Australia) believes the implementation of these Principles will lead to better outcomes for consumers and carers. The Network strongly endorses the Principles and encourages their uptake within clinical practice. The PMHA gratefully acknowledges the endorsements provided by the following organisations for the Principles and their willingness to promote the Principles within their organisations.

# > ACKNOWLEDGEMENTS

The ***Principles for Collaboration, Communication and Cooperation between Private Mental Health Service Providers*** (Principles) were developed under the auspices of the Private Mental Health Alliance (PMHA or Alliance) by its Collaborative Care Models Working Group (CCMWG). The PMHA gratefully acknowledges the support of the following organisations in the development and promotion of the Principles.

- Australian Medical Association — AMA
- The Royal Australian and New Zealand College of Psychiatrists — RANZCP
- Royal Australian College of General Practitioners — RACGP
- Australian Psychological Society — APS
- Australian College of Mental Health Nurses — ACMHN
- Australian Association of Social Workers — AASW
- Occupational Therapy Australia — OTA
- Australian Private Hospitals Association — APHA
- Private Healthcare Australia — PHA
- Private Mental Health Consumer Carer Network (Australia) — PMHCCN
- Australian Government Department of Health — DoH
- Australian Government Department of Veterans' Affairs — DVA
- Mental Health Professionals Network — MHPN
- General Practice Mental Health Standards Collaboration — GPMHSC

The contributions and assistance of the members of the CCMWG in the development of the Principles is gratefully acknowledged.

## > PMHA-CCMWG

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| **Chair and Secretary** | Mr Phillip Taylor | PMHA Director |
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| | Mr Patrick Hardwick | PMHCCN (Carers) |
| | Ms Robyn Milthorpe | DoH |
| | Ms Kym Connolly | DVA |

Further copies of the Principles can be obtained from the website of the PMHA at http://www.pmha.com.au

### Comments on the Principles

While we are confident that these Principles will go some way to supporting referral and communication between providers of mental health services in the private sector, we believe more work needs to be done in this area. CCMWG, therefore, welcomes comments and feedback on the Principles and any further advice as what future work might be necessary and what tools or other supports might be useful. All comments and advice should be forwarded to:

**The Director**
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# INTRODUCTION AND OBJECTIVE

## > Introduction

Over the last 20 years there has been a range of reform measures in mental health that have resulted in greater emphasis on care within the community, rather than in hospitals, or other centralised institutions. In particular, mental health reforms introduced by the Council of Australian Governments (COAG) in the last decade have focused on enhancing primary mental health care, predominantly by improving referral pathways between general practitioners and other mental health professionals.

By 2012, the majority[1] of Australians with a mental illness were receiving treatment and care in the private sector from a range of *mental health professionals*, including general practitioners (GPs), psychiatrists, psychologists, mental health nurses, social workers, and occupational therapists. Mental health services are also provided by private hospitals with psychiatric beds, private health insurers through chronic disease management programs, and by some government and Non–Government Organisations. The Australian health care systems' mix of private and public services means some people may be receiving treatment and care from both sectors to support their mental health care needs.

As the number of service providers in the private sector has increased, so has the number of possible linkages and communication pathways. In this context, the need for new processes for coordination and collaboration have emerged. A range of groups continue to work toward improving that interprofessional collaboration, as it has the potential to result in a more efficient and better experience for people with mental health care needs as they move through our health system and its mix of private and public services.

## > Objective

These Principles have been developed to support mental health professionals particularly in the private sector to collaborate appropriately, communicate effectively and, where necessary, share care. The interests of the consumer remain the guiding objective of care with a focus on recovery–oriented services. Referral systems should aim to define roles and responsibilities for everyone involved in the provision of care and lead to a consistent process of reliable follow–up, feedback and communication.

1 Refer to the review of available data sources presented in the Fact Sheet, of the PMHA Newsletter, 8th Edition, May 2011.

# GENERAL PRINCIPLES

## > General Principles

### 1. Consumer and Carer Involvement

In the tradition of patient centred care, engage with the consumer and their nominated carer concerning their goals and available treatment and support options . Seek and support their active participation in decision making about care and treatment options throughout the recovery journey.

Respect the role the nominated carer and any significant others play in caring for the patient and be responsive to their needs. When engaging with carers, or any significant others, providers should do so ethically and in accordance with their medico-legal responsibilities within their respective professional domains.

### 2. Continuity of Care

Continuity of care is the degree to which individual episodes of treatment and care are experienced by a consumer as being coherent, connected and consistent, as they move through the health system over the course of an illness, or injury. It involves the therapeutic relationship between the mental health professional and the consumer, well coordinated care across providers, and continuity of information for all those involved.

Continuity of care for people with a mental illness is particularly important and requires the following to be established and maintained.

- A sense of affiliation between the mental health professional, consumer and ideally their carers or other support persons.
- Consistency of care across the various providers including both public and private sector providers. All providers involved in the consumer's care should seek to ensure they are not working at cross purposes, which may compromise care.
- Continuity of information across episodes of care particularly through documentation, handover, and review of the records of previous consultations.

### 3. Communication

Communication should value each person's role. It should be timely, reciprocal, respectful and relevant. Be mindful of the potential opportunities to improve care coordination by involving others in certain aspects of care as appropriate.

# GENERAL PRINCIPLES

## 4. Roles and Responsibilities

The roles, responsibilities and scope of practice of mental health professionals and other service providers should be clearly defined, with due regard to the medico–legal responsibilities of each provider. In general, the GP should take on the role of coordinating the mental health care for the patient. Where that role is undertaken fully by another mental health provider, the GP retains responsibility for physical health care and remains part of the mental health team. It is particularly important for providers, consumers and carers, to understand clearly who is responsible for coordinating care.

## 5. Collaboration

Collaboration requires a shared understanding between the consumer, their carer(s) and mental health professionals about the aims of the services being provided. Collaboration includes monitoring these mental health outcomes and any necessary multidisciplinary discussions. There should be regular review mechanisms to evaluate how the collaboration is working in practice. All providers should ensure they do not express criticism of other providers, or their treatment regimes to the patient, or to their family. Any concern should be documented and addressed directly by the providers involved in the consumer's care.

## > Referrals

**Finding the right mental health professional, at the right time and in the right place, is complex. Issues of consumer preference and practitioner availability should inform these decisions.**

1. As a general rule, a Mental Health Treatment Plan (MHTP) is a sensible way to address coordination, follow–up and access to other referral pathways. It should be developed and regularly reviewed with the consumer by the GP, as the key coordinator of their medical care.

2. The purpose of a GP referral, including who actually suggested it (if not the GP), should be clearly documented. A brief summary of the health of the consumer, current and past treatments and medication and any relevant psychosocial issues the GP is aware of should be included. The categories listed under the Mental Health Treatment Plan can serve as a guide as to the type of information that might be useful to include. Clarity about the main purpose of the referral is important.

# GENERAL PRINCIPLES

3. Mental health professionals should provide feedback to GPs and other mental health professionals involved in a patient's treatment and care.

4. If someone other than a person's GP initiates a referral to another mental health professional, for example, when a paediatrician or psychiatrist refers someone directly to a psychologist, mental health nurse, social worker or occupational therapist, then the GP and the referrer should always receive regular feedback about the type of therapy being utililised, the patient response, and other useful information that is clinically appropriate to the patient. This may include duration and intervals of therapy and follow–up, and advice as to how the GP can assist in providing psychotherapeutic, or other relevant support.

5. Transition of care between mental health professionals also requires thoughtful collaborative practice. For example, if a GP refers a patient, who has been or is under the care of another mental health professional, to a different mental health professional, then consent from the patient should ideally be sought for sharing of information about previous care.

6. When a GP refers a consumer to a psychiatrist, the referral should be explicit as to whether it is only for an *opinion and report* (Medicare Benefits Schedule (MBS) Item 291), or whether it is for *ongoing management*. When *ongoing management* is requested by the GP, dialogue should occur with the psychiatrist regarding the level of ongoing GP involvement and how management roles will be shared between the GP and the psychiatrist.

7. While sequential referrals are preferable, in circumstances where simultaneous referrals occur, the referrer should ensure the providers are aware of the simultaneous referrals.

8. There should be transparency with regard to referrals. If in the opinion of a referrer, a person does not appear to be improving as anticipated, then it is expected that they will discuss this with the mental health professional providing the therapy.

# GENERAL PRINCIPLES

## > Sharing Care

Sharing care is relevant when a person's needs are complex, or when multiple service providers have become involved with a person in an ad hoc manner over time. Consider the need for shared care in the context of the psychiatric diagnosis, multi–morbidity, and social factors.

When a number of providers are simultaneously involved in a person's care, one way to facilitate and coordinate that care is to consider a shared care agreement. Such agreements may include the following.

- A requirement to clearly define who is responsible for what aspects of care and in what setting.
- Regular telephone, facsimile, SMS, mail, or secure email communication between providers, particularly in relation to any major change in the patient's health status, or medication.
- Stipulation that communication should be triggered when the following events occur.
  - > Any major change in the patient's mental health status.
  - > Any major change in treatment approach.
  - > A perceived increased risk of self–harm, or harm to others, as well as actual or impending drop out, or non–compliance with treatment.

Providers should seek to resolve any dispute or conflict about care with each other in the first instance. Second opinion mechanisms (for example referral for a psychiatric opinion using MBS Item 291) will often help resolve difficult scenarios. Unresolved disputes about care can have an adverse effect on consumer outcomes. In those situations where a shared care arrangement is no longer viable, appropriate arrangements should be in place to facilitate transition to another form of care for the consumer.

Develop communication protocols, including relevant arrangements for communicating with the patient's GP, and psychiatrist (when involved).

Specify arrangements for sharing relevant information from the patient's medical record.