Guidelines for Collaboration

Between

Queensland Health – Mental Health Services
Disability Services Queensland
And
Funded Disability Services Providers

In the Provision of Services to

People with a Dual Diagnosis of Intellectual Disability and Mental Illness
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INTRODUCTION

The prevalence of intellectual disability in the Australian population has been estimated at 1.86%. People with an intellectual disability are the largest group of disability services users in Queensland with approximately two-thirds (67.3%) reporting their primary disability as intellectual. The 1997 Mental Health and Wellbeing: Profile of Adults, found that almost one in five (18%) Australians had a mental disorder at some time during the 12 months prior to the survey.

Prevalence estimates of mental illness amongst people with an intellectual disability (dual diagnosis) range widely due to differences in methodology and definitions, varied interpretations of challenging behaviour, and according to the population studied. Nonetheless, it is accepted that the likely prevalence exceeds that for the general population, ranging between 30 – 40% across the different mental disorders and levels of intellectual impairment.

Serious mental health problems and mental illness occur amongst people with an intellectual disability 3 – 5 times more frequently than the general population. The existence of an intellectual disability provides no protection from mental disorder. Adults with an intellectual disability experience the full range of mental disorders found in the general population.

The increased risk of people with an intellectual disability to developing a mental health problem has attracted growing attention over the last few years. The Second National Mental Health Plan (1998) recognised a range of target groups for whom improved mental health service access and better service responses are essential. One of the target groups identified is people with mental illness and intellectual disability. The Strategic Plan for Psychiatric Services and Support 2000-2005 also identifies people with a dual diagnosis as amongst those who need improved access to the broad range of government and non-government services.

Adults with an intellectual disability who have a mental illness (dual diagnosis) often have complex and high-level support needs. There has traditionally been a great deal of energy directed towards determining which is the appropriate service to support people with a mental illness and an intellectual disability – disability services or mental health services. This can result in people receiving fragmented services or even no services. People with these complex needs often present in crisis which results in reactive service responses rather than a planned, proactive approach. There is nationally a paucity of the specialist expertise required to appropriately assess, support and provide ongoing management for this group of people.

In response to this identified need the Queensland Government’s Human Services Chief Executive Officer’s Committee has implemented the project: Improved Access to Services and Support to People with a Dual Diagnosis of Mental Illness and Intellectual Disability.

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3 Queensland Centre for Intellectual and Developmental Disability, University of Queensland, Sand in Society’s Machine: Models of Service Provision to Adults with an Intellectual Disability with Coexisting Mental Illness (Dual Diagnosis) August 2002
The project aims to establish and maintain collaborative practices between mental health and disability service providers as a fundamental step in improved quality of service provision for people with intellectual disability and mental illness. This will be achieved by establishing formal systemic mechanisms for collaboration at an organisational and individual level.

A planned approach to collaborative service delivery in local services will result in increased health and well being, increased community participation and quality of life for people with intellectual disability and coexisting mental illness by:
- Better meeting individual service and supports needs within local communities.
- Increasing stability of support arrangements and reducing crises.
- Increasing access to individualised, timely, planned and coordinated service mix.

GUIDING PRINCIPLES

1. People with an intellectual disability and a mental illness (a dual diagnosis) have the same rights to access appropriate mental health, disability and generic services as other members of the community.

2. Quality of life is ultimately benefited by innovative and flexible service practices and a commitment to the needs of people with a dual diagnosis.

3. Coordinated, individualised services that meet the needs of people with a dual diagnosis are best achieved by collaborative service partnerships and direct clinical and support services based on mutual respect, cooperation and shared principles.

4. Services to people with a dual diagnosis are provided within the existing legislative and policy frameworks, principles and standards underpinning each agency’s philosophies, policies and practices.

PURPOSE

The purpose of these Guidelines is to provide a broad framework for the provision of services to people with an intellectual disability and mental illness using a cooperative, collaborative approach that focuses on the needs of the person with a dual diagnosis.

HOW TO USE THE GUIDELINES

These Guidelines identify points in service provision where collaborative approaches are required. Agencies should implement these guidelines by undertaking the Actions as set out in each section. All inter-agency processes should reflect the both the Guiding Principles (below) and the specific Principles described in each section. The Features described in each section provide suggested strategies and processes that may assist agencies to develop local procedures in line with the identified principles. These local procedures will combine to act as agreed service delivery protocols between the agencies involved.

Attachments to these Guidelines provide examples of forms and procedures as developed as a result of implementing collaborative arrangements between mental health and disability services in local areas. These attachments are examples only and were developed to meet the specific needs of local areas. They may be helpful in assisting areas to develop local processes but do not necessarily reflect the arrangements other areas may wish to make.
FRAMEWORK FOR THE DELIVERY OF MENTAL HEALTH AND DISABILITY SERVICES IN QUEENSLAND

Mental Health Services

The primary goal of Queensland mental health services is to provide specialised clinical treatment and rehabilitation services that reduce the symptoms of mental illness and facilitate the recovery process. In doing this mental health services are responsible for a range of specialist services and supports that assist those most severely affected by mental illness, their families and other providers. Mental health treatment and rehabilitation services are provided by primary health care providers and specialised mental health services. Specialised mental health services are secondary and tertiary services, which are delivered by specialist mental health personnel.

Service delivery in Queensland is underpinned by the First, Second and Third National Mental Health Plans and the Queensland Mental Health Plan 1994 and the Ten Year Mental Health Strategy for Queensland 1996.

The Mental Health Unit, Corporate Office is responsible for progressing the development of mental health services. This includes coordinating the statewide policy directions and strategic framework for service development, supporting the development of the non-government sector, and the administration of the Mental Health Act and Regulations.

Public mental health services in Queensland are delivered at the District level by mental health professionals and organised according to geographically defined populations. Acute services (community and inpatient) encompass integrated processes for referral, consultation, liaison, assessment and treatment using a case management approach. All referrals are managed by the intake procedures established in each district mental health service. Under National and State directions for mental health reform, these services are particularly targeted to those people with mental disorders and serious mental health problems. This is to ensure that the people most at risk receive the treatment they need. This does not exclude access to treatment for people with a range of mental health problems which are serious in terms of their impact on quality of life or have adverse social consequences.

A dual diagnosis clinical program has been established as one of five extended treatment programs developed under the Ten Year Mental Health Strategy for Queensland (1996). This program targets people with a mental illness and a concomitant intellectual disability who require extended treatment and rehabilitation on a medium to long term basis.

Disability Services Queensland – Direct Services

Disability Services Queensland was established in December 1999 to provide a strong focus on disability across the Queensland Government.

Disability Services Queensland provides direct services to adults with an intellectual disability and high or complex support needs.

These services include:
- accommodation support in community and centre-based settings;
- therapy and specialist intervention; and
- support for individuals, families, and carers.
Services are provided in local communities through Area Offices. Each Area Office may vary in the type and extent of services it provides.

**Disability Services Queensland – Funding Programs**

Disability Services Queensland provides some funding to individuals in order to obtain services and supports that will best suit their individual needs. People may receive funding under the Adult Lifestyle Support, Post-School Services or Family Support Programs. Each program varies slightly in the way it is administered and applied. Funding is allocated on the basis of priority of need. People who wish to apply for individualised funding must register with Disability Services Queensland and submit an application for funding.

Once people have funding allocated to them a Supports Facilitator is identified to work with the person. The Supports Facilitator works with the person and/or their family to assist them identify their needs and put in place the services and supports to meet those needs.

**Funded Disability Services**

Disability Services Queensland provides some funding to a range of non-government, community-based organisations that support people with a disability.

Agencies may provide one or more service types. Under the Commonwealth State and Territories Disability Agreement, Disability Services Queensland funds the following service types:

- Accommodation support;
- Community support;
- Community access;
- Respite; and
- Advocacy.

Agencies vary in the extent and type of services they provide and in their identified client group.
WHO SHOULD USE THE GUIDELINES

These Guidelines apply to Disability Services Queensland, Queensland Health, Mental Health Services and funded disability services supporting a client who requires the services of more than one of these agencies.

The person will be an adult who has:

- a dual diagnosis of intellectual disability and mental illness; or
- an intellectual disability and may have a mental illness; or
- a mental illness and may have an intellectual disability.

**Mental Illness**

The Mental Health Act 2002 defines mental illness as “a condition characterised by a clinically significant disturbance of thought, mood, perception or memory”. The decision must be made in accordance with internationally accepted medical standards.

**Intellectual Disability**

Significantly below average intellectual functioning with onset before age 18 years and concurrent deficits or impairments in adaptive functioning (DSM-IV, 1994). Adaptive behaviour refers to the effectiveness with which a person meets the demands of daily living (such as eating and dressing, communication, locomotion, socialisation and responsibility).

**Dual Diagnosis**

This term is used to refer to people who have been diagnosed with two coexisting conditions. In the context of these Guidelines, it refers to people with an intellectual disability who also have a mental illness.
COMMUNICATION BETWEEN SERVICES

Principles

Identified communication channels are essential to facilitate an ongoing collaborative approach to service delivery.

Communication processes need to be jointly identified and formalised. They should be at two levels - a systems level, relating to organisational functioning and a work practice level relating to individual client issues.

Action 1: Operational Management Committee

Local mental health and disability service providers will establish an Operational Management Committee.

All Agencies should have a sound understanding of the services, available resources, eligibility criteria and priorities of all other agencies involved.

Action 2: Service Information Sharing

Agencies involved in implementation of the Guidelines will develop a process for sharing information that ensures agencies are aware of the type and extent of services available locally.

Features

The purpose of the Operational Management Committee is to provide a forum to promote coordination between service providers and to ensure the effective and efficient delivery of services to meet the needs of people with a dual diagnosis. It will identify issues at the systems level and make decisions about collaborative work practice. It has a role in the resolution of service responsibility issues. This group will comprise senior representatives of the participating agencies.

The Operational Management Committee will be responsible for:

- the development of a shared management approach;
- the sharing of information (within legislative and policy requirements);
- raising and resolving issues which arise at the agency and work practice level;
- monitoring the quality and consistency of joint individual service delivery;
- implementing data collection processes to enable monitoring of joint service delivery;
- progressing and monitoring the ongoing implementation of the Guidelines; and
- meeting and conducting business as specified under the Terms of Reference.

The Operational Management Committee may involve a combination of managers and direct service providers. A coordinator or chair of the Operational Management Committee should be identified. This role may be shared across agencies.

The Operational Management Committee will also be responsible for overseeing implementation of these Guidelines. This role may include:

- Establishing and maintaining effective mechanisms of communication between services. This may involve the provision of information about service roles and responsibilities and maintaining formal links with the other agencies;
Coordinating the development of collaborative processes regarding work practice activities between the two services;
− Monitoring and facilitating implementation of collaborative processes;
− Establishing and maintaining appropriate links with other stakeholders; and
− Identifying training needs and opportunities for meeting those needs, particularly in identifying opportunities for training between agencies.

Suggested Terms of Reference for the Operational Management Committee are provided in Attachment 1.

**Action 3: Liaison Officers**

Each agency involved in implementation of these Guidelines will identify an agency Liaison Officer.

**Features**

Identifying designated liaison officers within each service will ensure smooth communication, strengthen links and improve relationships between the services and other related stakeholders. A member of the Operational Management Committee may fulfil this role. The duties and particular amount of time devoted to this role will be determined at the local service level.

The role of the liaison officer will primarily be as a first or central point of contact into the agency particularly for information and referral purposes. Other liaison duties may be carried out by the liaison officer or another officer(s) as determined by the Operational Management Group.
REFERRAL

Principles

An individual’s access to an appropriate ‘mix’ of services is facilitated by service providers making, receiving and responding to referrals in a timely and appropriate manner.

Referral at the earliest possible time facilitates better outcomes for the individual.

People with complex support needs require more comprehensive and rigorous referral processes so that agencies may accurately ascertain eligibility for services.

Individuals may be in receipt of services from one or more agencies simultaneously. An offer of support from one agency does not prevent access to other service types.

Agencies may have expertise to offer in supporting people with complex needs who are not eligible for that agency’s services. Agencies may provide consultation, advice and support when a person is not eligible for ongoing services.

Action 4: Referral Procedure

Agencies represented on the Operational Management Group will develop an agreed procedure for referrals between agencies.

Features

The referral process should:

1. Reflect existing local referral procedures and meet existing organisational requirements including requirements for Information Privacy.

2. Identify a primary contact person for referrals in each agency. This person may be the liaison officer. This person will monitor the referral process by:
   − ensuring the use of the agreed referral process;
   − notifying other agencies of pending referrals;
   − accepting referrals and directing them appropriately within the agency; and
   − tracking outcomes of referrals.

3. Identify:
   − timeframes for response;
   − requirements for written documentation;
   − information required to accompany a referral; including:
     • consent for the referral and release of information
     • agreement within the referring agency on the need for the referral
     • previous assessments / screening assessments eg. the PAS-ADD checklist;
   − processes for determining and communicating the outcome of referral; and
   − processes for ongoing consultation and advice where a person is not eligible for services.

Example referral forms can be found in Attachment 2.
ASSESSMENT

Principles

Assessment can have multiple functions such as:
- making a diagnosis;
- determining eligibility and priority for services; and
- determining individual needs and service delivery goals.

Assessment to determine the presence of intellectual disability or mental disorder alone does not constitute assessment for service eligibility.

Both mental health and disability service providers have a role in assessment of dual diagnosis.

For people with intellectual disability, the symptoms and presentation of mental disorder and capacity of individuals to participate in assessment processes may vary.

Accurate assessment for people who may have a dual diagnosis usually requires:
- modified or specialised assessment tools and processes;
- multiple assessment sessions or an ongoing assessment approach;
- a collaborative approach to assessment between disability and mental health services;
- input of the person, their carers, family and friends; and
- familiar and/or multiple settings for assessment.

Action 5: Assessment Processes

Agencies will establish links and processes to allow for specialised and collaborative assessment of individuals who may have a dual diagnosis.

Features

Agencies should establish collaborative assessment processes where appropriate, that seek to:
- modify assessment procedures where appropriate to meet the needs of individuals including undertaking:
  - collaborative planning of assessment activities,
  - assessment in familiar or multiple environments, and/or
  - assessment over multiple assessment sessions;
- use specialised assessment tools where appropriate eg the Psychiatric Assessment Schedules for Adults with Developmental Disability (PAS-ADD);
- involve the person, their carers, family and friends in the assessment process;
- meet existing organisational assessment requirements including provision of information in accordance with Information Privacy standards; and
- seek additional expertise in dual diagnosis where required.
JOINT SERVICE PLANNING AND MANAGEMENT FOR INDIVIDUALS

Principles

Individuals who have a dual diagnosis may require the services of more than one agency. A collaborative approach by all stakeholders to ongoing joint planning, management and support will optimise the provision of care and support to this group of people.

All planning, management and support will be based on the individuals’ need and specific requirements. An approach which establishes a climate of joint responsibility, rather than primary responsibility, will ensure the efficient and effective use of interagency resources and reduce the need for crisis intervention.

Effective service planning requires the involvement of all stakeholders. The level of an agency’s direct responsibility for service provision may vary, depending upon the current needs and circumstances of the person.

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<th>Action 6: Joint Service Planning</th>
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<tr>
<td>Agencies will develop forums and processes to facilitate joint planning and service coordination for individuals.</td>
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</table>

Features

Any agreed process for Joint Service Planning and Management should meet existing service policies and requirements and should seek to incorporate the following features:

- Each service will continue to provide service coordination, specialist advice, support and consultation in relation to the person’s ongoing management irrespective of the service setting (inpatient or community).

- Service delivery for an individual will be planned, implemented and reviewed collaboratively with the person with a dual diagnosis, service providers and where possible, the person’s family, carer or advocate.

- Roles and responsibilities of each stakeholder will be agreed and documented.

- The agency who will take the lead responsibility needs to be identified where appropriate. This agency would be responsible for ensuring coordination, communication and overall monitoring.

- A nominated staff member from each service will be identified and be responsible for the ongoing communication and coordination of service delivery.

- Regular case conferences, involving all key stakeholders will be conducted to coordinate, monitor and review service delivery.

- Agencies will identify strategies to avert crisis situations and to determine contingencies should a crisis occur.

- All information, decisions and actions will be documented and shared.

An example Joint Service Planning and Management for Individuals Flow Chart is provided in Attachment 3.
CRISIS MANAGEMENT

Principles

Some crisis or emergency situations can arise without warning, while others are possible to anticipate. Where possible, every action should be taken to avert or reduce the impact of a future crisis situation.

Individuals in crisis require the swiftest possible collaborative action from all stakeholders who may be able to offer a response to their needs.

Good communication processes can lessen the impact of crisis situations.

Safety of the person, their carers and the community is the primary consideration in an emergency situation.

Emergency arrangements are short term in nature. Planning for long term arrangements should occur as soon as emergency arrangements are in place.

Action 7: Crisis Management

Agencies will develop processes to facilitate collaborative responses to emergency and crisis situations.

Features

Where possible, agencies should establish procedures to facilitate collaborative crisis responses that:

- Establish communication networks between stakeholders best placed to respond in emergency/crisis situations;
- Make known the available emergency response options in their area/agency and the situations under which these responses can be used;
- Establish links with other community services such as police and emergency services, hospital emergency departments; and
- Incorporate procedures for review of emergency arrangements.

To the extent possible, agencies should identify people at high risk of entering a crisis situation and should make contingency plans for situations that can be reasonably anticipated. This work should occur within the framework for Joint Service Planning and Management for Individuals.
RESOLUTION OF SERVICE RESPONSIBILITY ISSUES

The objective of this process is to guide discussions and provide a framework to resolve disputes between service providers regarding responsibility for service provision to the person with a dual diagnosis.

Principles

The person with a dual diagnosis, or their nominated support person, is able to pursue existing complaint or grievance mechanisms within Queensland Health and Disability Services Queensland. The person with a dual diagnosis, or their family, and service providers are able to seek the support of an advocacy group at any stage of the dispute resolution process.

Decisions about service provision are to reflect the responsibilities of service providers outlined in the Guidelines.

Dispute resolution is to be based on the expectation that all responses by service providers remain focussed on the best available and most appropriate response to meet the needs of the person with a dual diagnosis.

Service responsibility issues should be resolved at a local level and in a timely manner.

Mutually accepted outcomes should be documented and shared with all stakeholders.

<table>
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<th>Action 8: Service Responsibility Issues</th>
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<tr>
<td>The Operational Management Committee will develop a process for resolving service responsibility issues.</td>
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</tbody>
</table>

Features

It is likely that service responsibility issues will fall into two major categories:

1. **Issues impacting on services received by clients.**

   These issues should initially be addressed through an informal process with the immediate officers involved. If service providers are unable to resolve a service delivery issue around an individual at this level, then it should be referred sequentially, until resolved to the following forums:

   I. The joint planning and case conference meeting for the individual.
   II. The immediate supervisors involved and/or the Operational Management Committee.
   III. The appropriate management level.
   IV. Ultimate responsibility for resolution of service responsibility issues lies with the Executive Officers of each agency.

2. **Issues around the operation/work practices of agencies.**

   I. Systemic issues will be progressed initially through the Operational Management Group.
   II. Systemic issues unable to be resolved at this level should be referred for cross agency discussion and resolution at the appropriate management level.
   III. Ultimate responsibility for resolution of systemic issues lies with the Executive Officers of each agency.
Operational Management Committee

TERMS OF REFERENCE

Purpose
The purpose of this committee is to provide a forum to promote a coordinated system of care to ensure effective and efficient delivery of services to meet the needs of people with mental illness and intellectual disability in the ..........District/Region.

The goals of the Operational Management Committee are to:
1. implement the Guidelines for Collaboration in the Provision of Services to Adults with and Intellectual Disability and a Coexisting Mental Illness;
2. identify and promote opportunities for collaboration to enhance operational outcomes for the clients of the agencies; and
3. improve outcomes for clients through early intervention and the effective management of emerging crises.

Responsibilities
This committee will:
• progress and monitor the implementation of the guidelines
• develop a shared management approach
• share information
• raise and address issues at a systems level
  • resolve issues that arise at the work practice level
  • develop and implement changes in work practise to improve the quality and efficiency of care for people with mental illness and intellectual disability
• monitor the quality and consistency of individual management plans
• assist in the coordination of training and education for staff of participating agencies

Membership

Mental Health Service
Manager/Director
Team Leader for the first point of service entry
Team leaders of other relevant teams
Designated liaison officer
Representative from Emergency Department
Where appropriate, representative from Dual Diagnosis extended unit

DSQ
Area Manager(s)
Unit Manager(s)
Manager Professional and Specialist Services
Senior Resource Officer/Supports Facilitators
Representatives from relevant specialist teams
Designated Liaison Officer
**Funded Service Providers**  
Manager/Coordinator  
Representatives from relevant service units  
Representatives from relevant teams  
Designated Liaison Officer  

Other members from these agencies may be invited to discuss issues as the need arises.

**Meeting Protocols**

**Secretariat**  
*Convening of the meetings and preparation of an agenda and minutes of the meeting will be the responsibility of ............................*

**Chair**  
To be determined by the committee and will be rotated according to the agenda.

**Quorum**  
All nominated members need to be represented by a delegate to enable the committee to carry out its purpose, particularly with regard to the resolution of issues.

**Frequency of meetings**

- **Day:** The first Tuesday of each month, to be held monthly and to be reviewed in ..........  
- **Time:** 9.00am to 10.30am

**Venue**  
........................

**Reporting relationships**

Members of the Operational Management Committee will report to their respective senior officers on progress and issues arising from the meeting.

**Changes to the Terms of Reference**

These Terms of Reference may be altered following recommendations by the Operational Management Committee to the respective Directors/Managers.

**Date of Review**  
.............
REFERRAL TO:

WEST MORETON INTEGRATED MENTAL HEALTH SERVICE

<table>
<thead>
<tr>
<th>NAME:</th>
<th>AGE:</th>
<th>DOB:</th>
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ADDRESS: __________________________

REFERRED BY: ______________________

DESIGNATION: ______________________

AGENCY: ____________________________

Reason for referral

- [ ] Psychiatric Assessment
- [ ] Medication review
- [ ] Shared care
- [ ] Consultation/Liaison type: ___________

Next Of Kin/Guardian

________________________ contact no. ___________

Statutory health Attorney

________________________ contact no. ___________

Where to be seen

- [ ] Place of residence
- [ ] Outpatient clinic
- [ ] hospital

Urgency

- [ ] Priority
- [ ] Moderate
- [ ] Non urgent

Risk Indicators

- [ ] Suicidal
- [ ] Self harming
- [ ] Aggressive to others:
- [ ] Aggressive to environment:
- [ ] Sexual inappropriate behaviour
- [ ] Non-compliance to care ie: running away/refusing medication
- [ ] Dramatic Change in behaviour
- [ ] Other

Care Providers

- [ ] General Practitioner involved in referral
- [ ] Family full-time/part-time/casual
- [ ] Other full-time/part-time/casual

Next Of Kin/Guardian

________________________ contact no. ___________

Statutory health Attorney

________________________ contact no. ___________

AGENCY: ____________________________

Reason for referral

- [ ] Psychiatric Assessment
- [ ] Medication review
- [ ] Shared care
- [ ] Consultation/Liaison type: ___________

Next Of Kin/Guardian

________________________ contact no. ___________

Statutory health Attorney

________________________ contact no. ___________

Where to be seen

- [ ] Place of residence
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Urgency

- [ ] Priority
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Risk Indicators

- [ ] Suicidal
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- [ ] Aggressive to others:
- [ ] Aggressive to environment:
- [ ] Sexual inappropriate behaviour
- [ ] Non-compliance to care ie: running away/refusing medication
- [ ] Dramatic Change in behaviour
- [ ] Other
DEVELOPMENTAL DIAGNOSIS:

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REASON FOR REFERRAL:

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PRESENTING ILLNESS SYMPTOMS:

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SHORT HISTORY (SUMMARY)

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MEDICATION:

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SUPPORT NEEDS:

☐ Physical
☐ Interpreter
☐ Support person
☐ Other_______________

CHECK LIST:

☐ Consent
☐ GP’s approval
☐ Previous assessments
☐ Fax back form
PLEASE BE ADVISED THAT THE REFERRAL FOR THE ABOVE CLIENT HAS BEEN:

- **NOT ACCEPTED**
  - **Does not meet the criteria**
  - **For further information please contact:**
    - __________________
    - __________________

- **ACCEPTED**
  - **IMHS will contact you to develop an Assessment Plan**
  - Contact Person:
    - __________________
    - __________________
    - __________________

- **REQUIRES FURTHER INFORMATION**
  - **IMHS will contact you for further information**
  - Contact Person:
    - __________________
    - __________________
    - __________________

THANK YOU FOR YOUR REFERRAL.

REGARDS,

LIASON OFFICER
WEST MORETON INTEGRATED MENTAL HEALTH SERVICE
___/___/___
# Referral Form

**Attachment 2**

**Example Referral Forms**
(Ipswich/West Moreton)

## Referral to:

### Disability Services Queensland

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
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### Agency:

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### Reason for Referral

- [ ] Case Management (including Behaviour Support)
- [ ] Application for funding
- [ ] Behaviour Support
- [ ] Linking to services
- [ ] Consultation/Liaison
- [ ] Other ……………………………………

### Where to be seen

- [ ] Place of residence
- [ ] Outpatient clinic
- [ ] Hospital
- [ ] Other ……………………………………

### Urgency

- [ ] Priority
- [ ] Moderate
- [ ] Low

### Risk Indicators

<table>
<thead>
<tr>
<th>Suicidal</th>
<th>Self harming</th>
<th>Aggressive to others:</th>
<th>Aggressive to environment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual inappropriate behaviour</th>
<th>Non-compliance to care ie: running away/refusing medication</th>
<th>Dramatic Change in behaviour</th>
<th>Other</th>
</tr>
</thead>
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<td>__________</td>
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### Next Of Kin/Guardian

<p>| | | |</p>
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Contact no. _____________

### Statutory Health Attorney

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Contact no. _____________

### Care Providers

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<tr>
<th>General Practitioner</th>
<th>Family</th>
<th>Service Provider</th>
<th>Other</th>
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<tr>
<td>involved in referral</td>
<td>full-time/part-time/casual</td>
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### Level of Involvement

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<td></td>
</tr>
</tbody>
</table>
DEVELOPMENTAL DIAGNOSIS:

REASON FOR REFERRAL:

PRESENTING ILLNESS SYMPTOMS:

SHORT HISTORY (SUMMARY)

MEDICATION:

SUPPORT NEEDS:
- Physical
- Interpreter
- Support person
- Other

CHECK LIST:
- Consent
- Previous assessments
- Fax back form
DISABILITY SERVICES, QUEENSLAND
REFERRAL FEEDBACK TO
WEST MORETON INTEGRATED MENTAL HEALTH SERVICE

| NAME OF PERSON: | ................................................................. |
| DATE OF REFERRAL: | ................................................................. |
| REFERRED BY: | ................................................................. |

PLEASE BE ADVISED THAT THE REFERRAL FOR THE ABOVE CLIENT HAS BEEN:

- **NOT ACCEPTED** + Does not met the criteria
  
  For further information please contact:
  
  __________________
  __________________

- **ACCEPTED** + DSQ will contact you to develop an appropriate response
  
  Contact Person:
  
  __________________
  __________________
  __________________

- **REQUIRES FURTHER INFORMATION** + DSQ will contact you for further information
  
  Contact Person:
  
  __________________
  __________________
  __________________

THANK YOU FOR YOUR REFERRAL.

REGARDS,

LIASON OFFICER
WEST MORETON INTEGRATED MENTAL HEALTH SERVICE
__/__/__
DUAL DIAGNOSIS INTEGRATED RESPONSE PATHWAY

1. Client enters through any route

- Education
- Hospital
- Local GP

- Other
- Police
- Family

Usual gatekeeping incorporated in complex needs process

2. Other
- Generic Service
- Support
- NGO, Respite
- Disability Services Queensland
- Mental Health
- Other Counselling, Service

Dual Diagnosis Liaison/Referral Form
(incl. Info sharing authority)
Agency or Service completing the referral form becomes the Interim Case Manager

3. “Bridging the Gaps” network: Consultation between relevant services

No further action: advise referrer

Ongoing preparation & Liaison (eg DDU Links): services do detailed assessments

4. PERSON-CENTRED PLANNING MEETING
Preferably with client

5. Client needs identified

6. Lead Agency Case Manager Identified

7. P-C Case Mgmt plan identified & roles/responsibilities of services negotiated.

8. Service providers implement plans & inform lead agency Case Manager of changes in condition/situation. Review back through B the G Group, or exit to a single service when complex needs addressed or simplified