Memorandum of Understanding and Guidelines

Between Ageing, Disability and Home Care, Department of Human Services NSW and NSW Health In the Provision of Services to People with an Intellectual Disability and a Mental Illness

NSW GOVERNMENT

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November 2010

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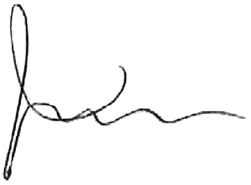
Acknowledgements

This *Memorandum of Understanding* has been developed in collaboration between Ageing, Disability & Home Care (ADHC), Department of Human Services NSW and NSW Health with the advice, guidance and the provision of specialist knowledge from the Intellectual Disability Mental Health Working Group (IDMHWG). This is a joint Working Group of both Ageing, Disability & Home Care (ADHC), Department of Human Services NSW and the NSW Mental Health & Drug & Alcohol Office (MHDAO), and includes representatives from ADHC Regions and NSW Area Health Services, Justice Health, the Children's Hospital of Westmead and the Chair of Intellectual Disability & Mental Health at the School of Psychiatry, University of New South Wales.

Acknowledgement is also given to the individuals and organisations that provided feedback throughout the development of this *Memorandum of Understanding* and the accompanying *Guidelines*.

Professor Debora Picone AM
Director-General
NSW Health
Date: 1 October 2010



Mr Jim Moore
Chief Executive
Ageing, Disability and Home Care NSW
Date: 1 October 2010

Glossary

- **Active service user** – "Active cases" refer to the status of service users who are registered with ADHC, have a current Individual Plan, a service agreement with the service user/family and are currently receiving services, including those supported by the funded services sector. These services are directed by the Individual Plan (see also 'service user' below).

- **ADHC services** – accommodation and/or other supports provided by ADHC staff or by a non-government organisation funded by ADHC to provide these services.

- **Area Health Service (AHS)** – of which there are eight in NSW.

- **Client** – See 'service user'.

- **Consumer** – typically people who are provided services in mental health services are referred to as consumers.

- **Correctional patient** – new forensic legislation has introduced a new category of patient: the 'correctional patient' – defined as a person (other than a forensic patient) who has been transferred from a correctional centre to a mental health facility as a "mentally ill person", for appropriate treatment and care.

- **Diagnostic & Assessment Services** – there are a limited number of Diagnostic & Assessment Services (DAS) in NSW that provide comprehensive health assessment for people with developmental disabilities.

- **Forensic patient** – a person who has been found:
  - unfit to be tried for an offence and ordered to be detained in a correctional centre, mental health facility or other place; OR
  - not guilty by reason of mental illness and ordered to be detained in a correctional centre, mental health facility or other place or released into the community subject to conditions.

- **Guardianship Tribunal (GT)** – a legal tribunal whose purpose is to facilitate decision making for people with a disability who lack the capacity to make certain decisions. The GT appoints guardians and financial managers, and consents to medical and dental treatment and may make a range of other orders. Whilst the GT's host department is the Department of Human Services, the GT is an independent body and operates under the *Guardianship Act 1987*. This Act sets out the limits of its responsibilities and functions and the principles to be applied when making decisions. The GT has specific and limited powers and can:
  - make guardianship orders to appoint a private guardian (family member or friend) and/or the Public Guardian
  - make financial management orders to appoint a private financial manager and/or the NSW Trustee
  - provide consent for treatment by a doctor or dentist
  - review enduring powers of attorney
  - review an enduring guardianship appointment and,
  - approve a clinical trial so that people with a decision-making disability can take part.

  The GT considers applications about people who normally reside in NSW or who have property or other financial assets in NSW. (For more information: http://www.gt.nsw.gov.au/)

- **NSW Trustee and Guardian (NSWTG)** – provides financial management services to people with a disability. Some people with a decision-making disability are not able to manage their own financial affairs and need someone with legal authority to make important financial decisions on their behalf.
  (In 2009, the Office of the Protective Commissioner (OPC), the Public Guardian (OPG), and the Public Trustee (PT NSW) were merged, and are now known as the New South Wales Trustee and Guardian (NSWTG)).

- **Mental Health Review Tribunal (MHRT)** – is a specialist quasi-judicial body established under the *Mental Health Act 2007*. It has a wide range of powers that enable it to make and review orders, and to hear appeals about the treatment and care of people with a mental illness (For further information: http://www.mhrt.nsw.gov.au/).

- **Intellectual disability (ID**) – The term intellectual disability has been used throughout this MOU Agreement to include people with an intellectual disability as well as people with low cognitive functioning.

- **Large Residential Centres (LRCs) and Specialist Supported Living** – ADHC provides specialised direct care services within contemporary accommodation models for selected ADHC Clients with special care needs. It also plans for the closure and possible redevelopment of ADHC operated large residential centres in line with *'Stronger Together: A new direction for disability services in NSW 2006-2016'*.

- **Mental Illness** – as defined in the *Mental Health Act 2007* a mental illness (e.g. depression, bipolar disorder, schizophrenia) is a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
  - delusions,
  - hallucinations,
  - serious disorder of thought form,
  - a severe disturbance of mood,
  - sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to above.
- **Service user** – term used throughout this MOU Agreement to refer to an ADHC or NSW Health client.

- **Statewide Mental Health Older Persons (SMHOP) Coordinators** – who coordinate services for Older Persons with Mental illness or Disorders for NSW Health.

SECTION 1

Introduction

This Memorandum of Understanding (MOU) has been developed by Ageing, Disability and Home Care (ADHC), Department of Human Services NSW, and the NSW Department of Health as a guide for Area Mental Health Services and ADHC disability services in the provision of services to people with an intellectual disability and a mental illness. This MOU is to be read in conjunction with the *Guidelines for the Memorandum of Understanding between Ageing, Disability and Home Care (ADHC), Department of Human Services NSW and the NSW Department of Health in the provision of services to people with an intellectual disability and a mental illness.*

The MOU commits the parties to work in cooperation to promote a safe and coordinated system of care. This will occur within a framework of continuous improvement to ensure the effective and efficient delivery of services to meet the needs of individuals with an intellectual disability and a mental illness (Part A in the accompanying *Guidelines for the MOU* outlines the Legislative and Non-Legislative framework in which this MOU sits).

Evidence shows that the prevalence of mental illness in children and adults with an intellectual disability is higher than that of the general population, and that this group often encounter barriers in accessing appropriate and adequate services. This agreement therefore is to facilitate this group in gaining access to services from both agencies if eligible. The overriding principles of this Agreement are that of choice and autonomy for service users.

NSW Health and ADHC offer different services to people with an intellectual disability and mental illness:

- NSW Health provides episodic health and illness services either in hospitals, correctional facilities, the community or in people's homes.
- ADHC directly operates, and funds non-government organisations (NGOs) to provide, accommodation facilities and community support programs for people with a disability.

There is also a range of affiliated disability and mental health service providers from the public, private and non-government sectors catering to the needs of those with an intellectual disability and mental illness.

Some people with an intellectual disability and a mental illness need to be clients of both a disability service and consumers of mental health services and this is why this MOU is important. A collaborative effort between both mental health and intellectual disability services will ensure that people with complex needs are provided with appropriate care.

This MOU supersedes all previous memoranda and policy directives will be effective from the date of the last signature of endorsement. It will remain in effect unless it is revoked, varied or modified in writing by signatory parties. The MOU is not intended to create a legally binding relationship between the parties. Nor does it override or detract from commitments entered into as part of existing agreements to which both agencies are parties.

From 1 January 2011, the current 8 Area Health Service (AHS) will be transitioned to 18 Local Health Networks (LHNs).

Eight LHNs will cover the Sydney metropolitan region, and seven will cover rural and regional NSW. In addition, two specialist networks will focus on Children's and Paediatric Services, and Forensic Mental Health. A third network will operate across the public health services provided by three Sydney facilities operated by St Vincent's Health. References herein to Area Health Services should be read to mean Local Health Networks. It is anticipated that Area Health Services and ADHC regional disability services will account for this transition in the establishment of any new local joint forums.

SECTION 2

Background

Prior to 1989, the provision of disability services in NSW was largely the responsibility of NSW Health. At this time service users with an intellectual disability and a mental illness were able to access both disability services and mental health services from the one agency. In 1990, a joint protocol *The Provision of Mental Health Services to People with Developmental Disabilities* was introduced detailing the responsibilities of government health and disability services and from this, the two agencies were formed. This protocol was reissued as a policy directive by NSW Health in January 2005. This MOU is intended to replace the NSW Health Policy Directive (PD2005_039 Mental Health Services to People with Developmental Disabilities).

SECTION 3

Purpose, Principles and Procedures

3.1 Purpose of this MOU

3.1.1 Enable the establishment of agreed working relationships based on shared responsibility for the provision of services to consumers whose needs overlap both agencies.

3.1.2 Ensure staff members are made aware of, and supported to access, the resources available to assist this service user group.

3.1.3 Improve access to disability and mental health services and improve treatment outcomes for service users and the support offered to families and carers.

3.1.4 Develop the parameters for a model for the sharing of data and information.

3.2 The Principles that will govern practice under this MOU

3.2.1 People with an intellectual disability and a mental illness have the same rights to access the full range of services provided by the NSW Government as other citizens.

3.2.2 ADHC and NSW Health are committed to providing services to clients whose needs overlap both agencies.

3.2.3 ADHC and Area Health Services have a responsibility to manage situations co-operatively, with an emphasis on the provision of preventative services, assessment, treatment and follow-up.

3.2.4 That people with an intellectual disability and a mental illness, their family members, carers, guardians and advocates should have the opportunity to take part in the planning, management and evaluation of treatment services.

3.2.5 That staff from both agencies are committed to understanding what it means to be a service user; to treating service users and their families, carers or guardians with respect; and allowing service users and their families, carers or guardians to voice their opinion about services and be supported to resolve these where required.

3.2.6 That the particular needs of the Aboriginal people of NSW who have an intellectual disability and mental health problems are met and that services provided should be tailored to meet the needs of this population group and are culturally sensitive and appropriate.

3.2.7 Services provided jointly should be of a consistent standard.

3.3 Procedures

3.3.1 **Joint Forums and Protocols in Service Planning and Development**

Each Region/Area of both agencies will establish joint forums and protocols for the purpose of formalising and facilitating local level arrangements for service provision.

3.3.2 **Access and Priority Issues**

Each agency will promote appropriate access to services through a range of strategies which include, but are not limited to, those listed in this agreement (e.g. collaborative service delivery, joint research and staff training).

3.3.3 **Referral and Assessment**

In relation to people with an intellectual disability, there is a complex interaction between physical and mental health symptoms. Behaviours that may suggest a psychiatric illness in a person with an intellectual disability may be due to an undiagnosed medical condition. For this reason, a comprehensive health assessment is required. At the local level (through the joint forums) both agencies will develop methods for information exchange between teams for the purpose of referral and/or assessment.

3.3.4 **Acute Care and Immediate Response**

On occasion, staff members in supported accommodation or community services may require the intervention of mental health services and/or the police when they believe the service user requires acute care. The person may or may not have been diagnosed with a mental illness at that point. Acute care occurs when the service user is behaving in a very bizarre or unusual manner (where this is thought to be due to mental illness) and/or there are concerns regarding the person's safety or the safety of others.

It is expected that local joint forums will develop service and location specific protocols that detail the precise mechanisms by which each department will request the involvement of the other.

3.3.5 **Service Coordination/Case Management and Dual Management**

Where service users require services from both agencies, a joint case meeting will be held to determine the areas of responsibility, specific roles, actions, time-frames, the monitoring process and a review date. The family, carer or guardian should always be involved in this process.

3.3.6 **Service User Information – Privacy and Information Exchange**

Staff members of both agencies will need to exchange confidential information about service users in order to develop and coordinate services. This information will be exchanged only under circumstances where this will be in the best interests of the service user.

3.3.7 **Handover Responsibility**

When the mental health team has completed the treatment program, a written summary of the treatment program and outcomes, and/or the relevant Mental Health Outcomes and Assessments Tools (MH-OAT) will be provided to the service user and, with appropriate consent, to the ADHC case manager and other relevant stakeholders. This summary will also cover the issue of follow-up care.

When an ADHC service has completed its work with a mental health service user, a written summary of services provided should be provided to the mental health case manager.

3.3.8 **Transfer to other locations**

A service user with an intellectual disability and a mental illness may transfer to another location in NSW. In such instances it is important to ensure continuity of care is preserved with a prompt transferring of information to the receiving services. Joint responsibility will be taken by staff from both agencies to prepare a summary of the service user's Individual Plan or treatment program. This summary will detail: the diagnosis, treatment, behaviour support plan, and the review date. This will be forwarded to the respective disability and mental health teams in the consumer's new location.

Relevant information will be provided to the new location, and the information on the Service User System will be updated. The appropriate consent form for this process is to be signed by the service user and/or their guardian.

The continuity of care is also to be facilitated between the relevant Area Health Service and Justice Health.

3.3.9 **Accountability**

For the purpose of this MOU, 'accountability' is defined as: ensuring that appropriate mechanisms are in place and that all staff have clear responsibilities in relation to service provision.

The joint forums (as outlined in 3.3.1 above) have the responsibility of developing accountability mechanisms suitable for their own Region/Area as well as the reporting arrangements (e.g. six-monthly reports to the ADHC Regional Director and Area Mental Health Services Director).

3.3.10 **Training**

All signatory parties will collaborate to ensure that professional development and training programs are provided and reviewed regularly so that content is relevant and reflects the intent of this MOU.

SECTION 4

Dispute Resolution

The prevention and minimisation of disputes will be assisted by staff of both agencies receiving the appropriate training about the MOU and its protocols. Disputes between the two agencies relating specifically to this MOU will be resolved in the following manner:

- All staff shall, in the first instance, endeavour to resolve any disputes at a local level through the joint forums.

- It is expected that a dispute resolution process is developed by, and clearly articulated across, both agencies in the joint forums. This process is to outline clear timeframes and avenues for escalation as appropriate, with the arbiter finally being the Regional Director (ADHC) or Area Mental Health Director.

- In the event that this process is unable to resolve any dispute, the matter shall be escalated through the relevant management channels for determination with the ultimate arbitrator being the Deputy Director-General of each agency.

SECTION 5

Implementation

The Intellectual Disability Mental Health Working Group (IDMHWG) will have oversight of the implementation of this MOU and its attached Guidelines. The implementation and governance of the MOU will be a joint process between ADHC and NSW Health.

SECTION 6

Communication and Strategy

It will be the responsibility of the joint forums to develop a communication strategy that outlines how the information contained within this MOU and Guidelines is disseminated and implemented by all staff.

SECTION 7

Review of the Memorandium

The monitoring and evaluation of this MOU is an essential component for ongoing improvement of agency partnerships and service delivery. The final evaluation of the MOU will be conducted by the IDMHWG 18 months after implementation. The Working Group will then provide a report to the ADHC/Health Senior Officers Group (SOG) on the outcomes of this evaluation.

Guidelines for the Memorandum of Understanding

Between Ageing, Disability and Home Care, Department of Human Services NSW and NSW Health In the Provision of Services to People with an Intellectual Disability and a Mental Illness

Guidelines Contents

Introduction

These Guidelines should be read as an accompaniment to the *Memorandum of Understanding: between Ageing, Disability & Home Care (ADHC) Department Human Services NSW and NSW Health in the provision of services to people with an intellectual disability and a mental illness*.

These Guidelines outline processes and procedures that will assist your clinical practice at the Regional/Area level in providing the best possible treatment for people with an intellectual disability and a mental illness, whose needs often overlap.

These Guidelines outline the steps to take in the event of: a person presenting to a mental health inpatient service; those to take when a person already known to ADHC services may require a referral to a mental health service; and those to take when a person in a mental health service requires a referral to ADHC services. These provide a guide only and it is anticipated that other referral and assessment pathways that may arise will be addressed by the local Regional/Area Joint Forums. These Guidelines also provide detail about the functions of each agency and the requirements of special needs groups within this consumer group.

These Guidelines have been developed alongside the MOU and have been the result of wide consultation across both Ageing, Disability & Home Care (ADHC) and NSW Health.

PART A

Legislative and Non-Legislative Framework

The following provides an outline of the legislative and non-legislative framework in which the 'Memorandum of Understanding' sits.

Legislative Framework

- *The Disability Services Act 1993*
  This Act: provides for the funding and provision of disability services; sets out the terms and conditions on which non-government organisations receive funding; and provides for decisions made by the Minister under the Act to be reviewed by the NSW Administrative Decisions Tribunal.
- *The Mental Health Act 2007*
  This Act ensures the provision of care, treatment and control of persons suffering mental illness or mental disorders. The Act contains principles for the care and treatment of patients.
- *Mental Health (Forensic Provisions) Act 1990 (formerly the Mental Health Criminal Procedure Act 1990).*
- *Human Rights and Equal Opportunity Commission Act 1986*
- *Freedom of Information Act 1989*
- *Guardianship Act 1987*
  This Act was created to protect the legal rights of people over the age of 16 years, who have a disability which affects their capacity to make decisions.
  In 1989 the Guardianship Act created the NSW Guardianship Tribunal and the Office of the Public Guardian. In 1998 it was amended to allow for the appointment of enduring guardians. In 2004 the Act was again amended to enable the NSW Administrative Decisions Tribunal to hear appeals against decisions made by the Guardianship Tribunal and to review decisions of the Office of the Public Guardian.
- *Privacy and Personal Information Protection Act (1998)*
- *Children and Young Persons (Care and Protection) Act 1998*
- *Anti-Discrimination Act 1977*

Non-Legislative Framework

- *NSW Mental Health Plan 2005-2010*
- *NSW Interagency Action Plan for Better Mental Health (2005)*
- *Government's Statement of Principles for People with Disabilities and their Families in New South Wales (1989*)
- *Council of Australian Governments (COAG) National Action Plan for Mental Health 2006-2011*
- *United Nations (UN) Convention on the Rights of Persons with Disabilities 2007*
- *NSW State Plan 2010*
  The following priorities from the NSW State Plan are applicable to this MOU:
  Healthy Communities:
  – Improve and maintain access to quality healthcare in the face of increasing demand
  – Improve outcomes in mental health
  Stronger Communities:
  – Support people with a disability.

PART B

Joint Regional/Area Forums

It will be the role of the joint forums (or any existing ones) (see 3.3.1 of the *Memorandum of Understanding*) to undertake service planning and development. It is suggested that the forums meet on a quarterly basis.

The two main areas to be considered by these joint forums are:

- *Clinical Care Planning* – discussion of cases that require joint clinical management from both agencies and provision of advice/ recommendations. It is anticipated that this would involve participation by direct service providers of both agencies.
- *Service Planning* – discussion of the strengths, challenges, risks and gaps in service provision, and the development of plans to address these. This may lead to joint submissions for funding.

The composition of the joint forums will include senior managerial and operational staff from each agency. For example:

ADHC

- Deputy Regional Director
- Senior Specialist Psychologist
- Manager, Behaviour Support
- Senior Manager, Community Access
- Director, or designate, ADHC funded NGO.

NSW Health

- Clinical Partnership Coordinators
- Director, Area Mental Health Service
- Director, Clinical Services
- Nurse Unit Manager
- Senior Social Worker
- Team Leaders, Mental Health Service
- Senior Clinician, Drug and Alcohol Services
- Director, or designate, NSW Health funded NGO.

In addition to the recommended members above, these forums may include staff representatives from Justice Health, ADHC accommodation services, the Disability Health/Diagnostic Assessment Services (DAS), local NGOs and representation from drug and alcohol services, Aboriginal & Torres Strait Islander and Culturally & Linguistically Diverse communities.

Service User Representation

Service users, providers and advocate groups may also be invited to participate in the joint forums as required to discuss service planning. Their involvement in joint forums will provide an opportunity for valuable feedback to both agencies. Feedback received from service users, their families and carers is important to the ongoing improvement and monitoring of service provision. This feedback can be a standing item on the agenda for the forum or gathered by way of questionnaire or satisfaction surveys.

Service Provider Partners

Service provider partners such as the Department of Human Services, local Diagnostic & Assessment Service (DAS) and other disability organisations should also be invited to participate where appropriate.

Suggested terms of reference for Joint Forums

1. To facilitate a regular forum for discussing and resolving issues that affect local area service provision. Such issues may include: resource and clinical management, and specific operational, policy and procedural issues.

2. To clarify roles and responsibilities of staff members working in both services. To establish joint clinical management of service users common to both services where appropriate through case discussion and clinical forums.

3. To develop a two year plan to assist the forum in integrating Local, State and Commonwealth policy directions with local practice.

4. To act as a vehicle for relevant local procedural development, review, dissemination and to provide a forum for feedback in relation to relevant policy.

5. To provide feedback on planned changes to service delivery that will have an impact on the target population and to monitor the committee progress and implementation.

6. To develop databases to record referral and service provision. This database should record a potential patient's cultural background in order to tailor service appropriately.

7. To undertake joint planning for the enhancement of existing services and development of new services. This would be conducted via coordinating working parties to consider specific issues, and producing examples of best practice. This would also include examining research proposals and project reports for arising issues/current research.

8. To develop appropriate mechanisms for communication, such as lists of key contact people and telephone numbers that will foster cooperative and accessible joint service provision at the local level.

9. To develop, implement and monitor continuing education and training in both services to enhance service delivery, or where available, tie in with existing mechanisms for this.

10. To provide quarterly updates to the Intellectual Disability Mental Health Working Group (IDMHWG) on outcomes and any systemic issues arising from the joint forums.

PART C

Referral and Assessment

In order to take account of the possible medical causes for a person with an intellectual disability presenting with challenging behaviours, a comprehensive health assessment is required.[1] The following outlines some steps for effectively managing the assessment and referral process across both agencies.

Where ADHC staff members consider that a referral to a mental health service is necessary, they will prepare a clear and detailed summary (see below Service User Information – Information Exchange & Privacy) of the service user's history and the reasons for making the referral. This summary will be compiled in collaboration with the service user, and their family members, guardians and/or carers (where appropriate and possible).

Acute care and immediate response

For ADHC and disability service staff

When making a referral that requires an immediate response from the mental health service or the police, staff of the disability services should provide at least the following details of the service user:

- Name
- Date of birth
- Address
- Cultural background
- Current location of the person
- Presenting problem
- Behaviour of the person and level of functioning
- Other services and people involved/social context of the service user
- Presence or availability of staff members
- Evidence of firearms, dangerous weapons or drugs.

These details allow mental health services or emergency department staff to check to see if the person is known to mental health services and if specialist services such as Aboriginal health workers or interpreters are required. If a referral is made to an acute care team, mental health service staff will ask specific questions to decide on the basis of the information available whether there are indicators of a mental illness and what the appropriate response should be. Options for responding include telephone advice, consultation at the scene and direct psychiatric assessment.

Acute care/emergency mental health service staff may conduct assessments in a range of locations including local General Practitioners (GP) surgery, hospital emergency department, the police station, the service user's family, group home or day placement.

For NSW Health staff

If, once a service user has been referred to the mental health service, the service has concerns about a service user's need for safe accommodation support and their clinical care; these should be highlighted for an immediate response from ADHC. The circumstances in which such a response would be required include:

- Homelessness – this would include, but is not limited to, the service user inappropriately occupying a respite or mental health bed, or remaining in custody due to lack of accommodation.
- Service users displaying challenging behaviour such that they are at risk of becoming involved in the criminal justice system, or who have already been involved with the criminal justice system and are at risk of re-offending.
- Service users whose continued living in the community is contingent on their receiving services as a condition of bail, bond, or parole etc.

1 van Schrojenstein Lantman-de Valk HM. Walsh PN. Managing health problems in people with intellectual disabilities. BMJ. 337:a2507, 2008
Cooper SA, Melville C, Morrison J. People with intellectual disabilities. BMJ 2004; 329:414-5
Beange H, McElduff A, Baker W. Medical disorders in adults with intellectual disability: a population study. Am J Ment Retard 1995; 99(7): 595-604

- Where a service user is at imminent risk of entering more restrictive accommodation and/or whose carer is likely to be at risk, unless entry into the service is facilitated. This may include service users who are at risk of incarceration or re-incarceration. It may also apply to young people who have been, or are at risk of being, inappropriately placed in an aged care facility.
- Where there is a life-threatening risk to the service user or they are experiencing a serious deterioration in health.

For service users presenting to a mental health service

The following outlines the procedures when service users with an intellectual disability and a mental illness present or are referred to a mental health inpatient unit.

Service user is already receiving ADHC services:

1. Determine a staff member on the inpatient unit who will be the single point of contact (e.g. registered nurse, psychiatric registrar, social worker, or psychologist) for the service user.

2. The identified staff member should initiate contact with the ADHC key contact (usually a case manager – alternatively Steps 1 and 2 could be vice versa) as close to the time of admission as possible.

3. An ADHC key contact should ensure the following stakeholders (where applicable) are aware of the admission as soon as possible:
   – ADHC Deputy Regional Director
   – ADHC Psychologist or Behaviour Support Practitioner
   – ADHC Regional Manager Accommodation and Respite
   – ADHC Manager Access (of Case Management team).

4. Key contacts from ADHC and the mental health inpatient unit to maintain contact at least weekly. The key contact from the inpatient unit should inform the ADHC key contact of the day/time of the weekly ward rounds, so that the ADHC key contact and Behaviour Support Practitioner/psychologist can attend.

5. This will enable the ADHC team to be aware of the diagnosis and plan of the inpatient intervention, and the outcome of any meetings with the Mental Health Review Tribunal (MHRT) and to provide clarity regarding the service user's history and usual presentation.

6. Copy of the inpatient care plan to go to the ADHC Behaviour Support Practitioner/Psychologist; and any relevant assessment notes (with consent).

7. The key contact in the inpatient unit should ensure that the ADHC key contact is aware of the planned date of discharge and all details of the discharge care plan (provide copy of D1 form).

8. Joint home visit to be arranged prior to discharge (applicable only where mental health services are planning to be involved in the service user's follow-up post-discharge).

9. ADHC key contact to ensure that all ADHC stakeholders are aware of the planned date so that internal services can be coordinated.

Service user is currently already receiving mental health services:

1. The mental health treating team to determine a person in the inpatient unit who will be the single point of contact (e.g. registered nurse, psychiatric registrar, social worker, or psychologist).

2. A key contact from mental health to initiate a phone call to the ADHC Regional Information, Referral & Intake (IRI) team as close to the time of admission as possible.

3. The ADHC Regional IRI team to classify if the situation is requiring an immediate response and allocate a case manager as a high priority where a service user is a mental health inpatient. If the service user is not eligible for ADHC services then an ADHC Regional Options Coordinator (ROC) would contact the mental health key contact to organise referrals.

Service coordination/case mangement and dual management

In some instances, ongoing coordinated case management of a person with an intellectual disability and a mental illness across both agencies may be required. This involves:

- Mental health services maintaining a liaison and specialist consultancy role.
- ADHC and mental health services ensuring the involvement of carers, family members or guardian in the decision-making about planning and delivery of services to the service user.

- ADHC and mental health services ensuring that clear agreement is reached with the service user, the family, the 'person responsible' or the guardian regarding on-going mental health support.
- ADHC and mental health services agreeing on which lead agency should take responsibility for implementing and coordinating the development of the case plan.
- ADHC and mental health services ensuring that all service user supports are appropriately integrated.
- ADHC and mental health services conducting regular reviews with the service user. This is particularly important for service users on long term psychotropic medications which can have negative (and occasionally irreversible) side effects such as tardive dyskinesia (involuntary, repetitive movements).

Service user information – information exchange and privacy

It is expected that the information gathered about service users will not be used, or disclosed, for any other purpose except with consent unless it is absolutely necessary to prevent harm to life or health. The information compiled in the summary for exchange between agencies will consist of:

- Current level of functioning
- Mental health concerns
- Behavioural issues
- Social context and key relationships
- Cultural background, i.e. Aboriginality or CALD
- Communication issues
- Current accommodation
- Medical background
- Services currently accessed
- Specialist involvement

It is expected that all parties to the MOU comply with the following laws, policies and protocols in respect to any collection, use or disclosure of personal information or personal health information:

- *The Privacy and Personal Information Protection Act 1998 (NSW)* provides for access to personal information held by public sector agencies.
- *The Health Records and Information Privacy Act 2002 (NSW)* provides for an individual to obtain access to their health information.
- Any internal policies, protocols and procedures issued by the two agencies in relation to privacy or information management.

Referral and assessment – for each agency

ADHC to NSW Health

At the initial assessment with a mental health service, ADHC staff (e.g. key worker or case manager) will accompany the service user and family members or person responsible to the mental health service for the assessment and be prepared to give any necessary information, if required by the service user and family, and negotiate any ongoing support required throughout the assessment process. Mental health services will advise ADHC staff of the outcome of their assessment of the service user and their ongoing plan of care.

NSW Health to ADHC

Where NSW Health staff consider that a referral to ADHC is necessary they will provide all available up to date documentation to support the individual's request for service. The ADHC intake function will support an individual with a disability to access a range of services. In order to support a referral, the documentation supplied will assist to identify:

- Intellectual functioning measured at two or more standard deviations below the mean for the full-scale score on a recognised test of intelligence.
- Significant deficits in adaptive functioning in two or more areas (significant is defined as two or more standard deviations below the mean or equivalent. The areas of functioning must be factors or domains, not subscales). Recognised norm referenced tests include: Vineland ABS, Woodcock Johnson SIB, and AAMR ABS-R.
- That these deficits in cognitive and adaptive functioning are manifest prior to 18 years of age.

If not eligible for ADHC-provided services then the ADHC Regional IRI team will provide relevant support to identify alternate services for referral.

As part of the handover to the other agency, NSW Health & ADHC staff will provide a summary of current services as stated above. This will be presented to the central intake team of the relevant ADHC Region or on admission to a mental health unit or emergency department.

In the event that there is disagreement as to eligibility for either mental health or disability services, the interested parties will discuss the case together in the first instance with the view to achieving the best outcome for the service user. In more complex cases where a resolution cannot be reached between agencies, a second opinion may be sought and relevant senior management involved. A reciprocal arrangement will exist for both agencies allowing staff the opportunity for follow-up and clarification on an assessment. It is anticipated that the specific protocol for this will be developed at the joint forum level.

Dispute resolution

It is anticipated that the local Region/Area joint forums will develop a dispute resolution process and that this will be clearly articulated across both agencies. This will include detail about escalation procedures in the event that resolution on a dispute cannot be found.

Roles and responsibilities

The following provides guidance on the roles and responsibilities of each agency throughout the referral, assessment and treatment process.

ADHC's responsibilities:

ADHC will work collaboratively with mental health services and continue to be responsible for:

- Ensuring the participation of key individuals and groups.
- Inspiring a strong, non-judgemental, service user-centred approach.
- To undertake comprehensive assessment of referred service users in relation to their intellectual disability/ cognitive functioning.
- To work collaboratively with the mental health team on appropriate action for the management of service users with complex needs.
- Working with the mental health team to produce an individualised service and support plan.
- Convening case conferences where required.
- Identifying existing services and assessing their usefulness to the needs of the service user and his or her family or guardian.
- Working with the service user and his or her family or guardian to create a crisis plan.
- Ensuring that the accommodation and support services for the service user are maintained.
- Identifying any additional priority needs of the service user and making appropriate referrals.
- Monitoring the service user's progress through treatment.
- Assisting with implementation of the treatment plan, for example, administration of medications and the Behaviour Support Plan.
- Ensuring a smooth transition for the service user from inpatient hospital treatment to the family home or alternative supported accommodation.
- Ensure a joint follow-up process is included in any discharge plan from an acute care facility.
- Reviewing arrangements for care by ADHC funded services where it appears that the care needs of an individual with an intellectual disability and mental illness appear to be changing and where additional services may be required to support the most effective care for the individual.
- And overall, assessing the training needs of key individuals in supporting the service user and arranging for further training where required.

NSW Health's responsibilities:

NSW Health will work collaboratively with disability services and will continue to be responsible for:

- Ensuring the participation of key individuals and groups.
- Inspiring a strong, non-judgemental, service user-centred approach.
- Convening case conferences where required.
- To undertake comprehensive assessment of referred service users in relation to their mental health status. The psychiatrist or the key member of the community mental health team has responsibility for diagnosis of the mental illness or disorder and their treatment plan. Development of the treatment plan requires input and consent from the service user, his or her guardian, or a family member who fits the definition of 'person responsible'. (*The Guardianship Act 1987* spells out who can give consent to medical and dental treatment for people who are unable to understand the nature and effect of the treatment).
- To determine and initiate appropriate treatment in consultation with the disability services case manager where a mental health illness or disorder is present, after consent has been obtained from either the service user or the 'person responsible'.
- To work collaboratively with ADHC on appropriate action for the management of issues which are not deemed to be a mental illness.

- To work collaboratively with the ADHC case manager in consultation about ongoing treatment issues, including side-effects and complications.

- To collaborate with the ADHC case manager in the development of Behaviour Support Plans for the service user, where appropriate.
- To detail the necessary aspects of post-acute treatment, including psychological, pharmacological and social requirements.
- To liaise with ADHC to ensure that the service user is receiving optimal treatment post-discharge from the service.
- To raise any accommodation and support concerns to the attention of ADHC staff.
- Ensure a joint follow-up process is included in any discharge plan from an acute care facility.
- To arrange appropriate mental health follow-up where necessary.
- And overall, to assess the training needs of key individuals in supporting the service user and arranging for further training where required.

PART D

Services Provided by Each Agency

ADHC

ADHC assists older people, people with a disability, and their families and carers within the community. This is achieved through delivering a diverse range of services and support programs.

ADHC provides or funds services for people with a disability as defined under the *Disability Services Act 1993*. Only those individuals with an 'intellectual disability' are eligible for ADHC services. This is defined as:

- Intellectual functioning measured at two or more standard deviations below the mean for the full-scale score on a recognised test of intelligence.
- Significant deficits in adaptive functioning in two or more areas (significant is defined as two or more standard deviations below the mean or equivalent. The areas of functioning must be factors or domains, not subscales). Recognised norm referenced tests include Vineland ABS, Woodcock Johnson SIB, and AAMR ABS-R.
- That these deficits in cognitive and adaptive functioning are manifest prior to 18 years of age.

Those outside of these criteria may be eligible for services provided by the non-government sector, or those services provided by NSW Health.

In the event that a person with a disability that is not deemed an 'intellectual disability' seeks assistance from ADHC, they will be provided with information about available services and a referral will be made to an appropriate funded organisation.

Regional Services

ADHC is divided into six regions: Metropolitan North, Metropolitan South, Northern, Western, Southern, and Hunter (see map at Part H below). Each region is managed by a Regional Director. Services within each region are requested via a central intake process and these services include accommodation, respite, case management, psychology, behaviour support and allied health services.

Statewide

The Department provides two specialist state-wide programs; these are the Community Justice Program (CJP) and the Statewide Behaviour Intervention Service (SBIS). The CJP provides casework, clinical and accommodation services for people with an intellectual disability exiting custody. The SBIS is a tertiary level service which accepts referrals from, and provides clinical consultation to, all NSW government and non-government agencies working with people who have an intellectual disability and significant challenging or offending behaviour.

These two programs are managed by the Office of the Senior Practitioner (OSP) which was established in 2006 under ADHC's Stronger Together Plan to provide leadership and coordination of services to those with complex behaviours.

In the event that a person receiving services from ADHC also has a mental illness they will be supported to access services. Their support needs in relation to their mental health will be incorporated into an Individual Planning (IP) process.

NSW Health

NSW Health works to provide the people of NSW with the best possible healthcare via the provision of a diverse range of services and support programs.

Area Health Services

There are eight geographical Area Health Services (AHS) (see map at Part H below) responsible for providing health services, including mental health services, in a wide range of settings, from primary care posts in the remote outback to metropolitan tertiary health centres.

The Area Health Services are: Greater Southern, Greater Western, Hunter New England, North Coast, Northern Sydney Central Coast, South Eastern Sydney & Illawarra, Sydney South West and Sydney West. Each AHS is administered by a Chief Executive. Mental health services within each Area are administered by an Area Director.

The specialist public Area Mental Health Service (AMHS) system sits within the general healthcare system, and has particular responsibility for the care of people with mental illness.

Mental health services within each AHS consist of a range of services that may include inpatient mental health care (such as non-acute inpatient care) and community and mental health services (such as acute and emergency care and treatment, specialist community mental health services incorporating assertive community treatment services and care coordination services; mental health rehabilitation services, and services provided by Aboriginal Medical Services).

All Areas have 24-hour access to mental health services on an on-call basis at least. At a minimum, in some Areas, this will be contact via telephone for consultation.

Ambulance Service of NSW

The Ambulance Service of NSW is responsible for providing responsive, high quality clinical care in emergency situations, including pre-hospital care, rescue, and retrieval and patient transport services.

Statutory Health Corporations

There are five statutory health corporations, which provide state-wide, or specialist health and health support services including Children's Hospital Westmead and Justice Health.

Children's Hospital at Westmead

The Children's Hospital at Westmead is a service dedicated to paediatrics providing community medical care, paediatric emergency and tertiary level paediatric services.

Justice Health

Justice Health provides health care in complex environments such as the adult correctional system, courts, police cells, juvenile detention centres, and to those people within the NSW forensic mental health system and in the community.

Justice Health works closely with a variety of other organisations. These include: NSW Health, Department of Corrective Services (DCS), Department of Juvenile Justice (DJJ), Area Health Services, Community Controlled Aboriginal Health Organisations, NSW Police Force, Attorney-General's Department, universities, community and advocacy groups.

Diagnostic & Assessment Services (DAS)

In NSW, there are a limited number of local Disability Health Service/Diagnostic & Assessment Services that provide comprehensive health assessments for people with a developmental disability.

Both NSW Health and ADHC provide a continuum of support where more intensive services are provided in response to more complex needs (Part G below provides a diagrammatic explanation of this).

PART E

Special Needs Groups

ADHC and NSW Health services will have different protocols and procedures for managing the requirements of the following special needs groups. The following information is provided as a guide only and it is anticipated that any further specific information will be provided by the local protocols developed at the joint Regional/Area level.

Children and adolescents

The great majority of children and young people with an intellectual disability and mental illness who receive treatment do so in a community setting. In some instances, children and adolescents may require 1:1 nursing care ("specialling") during their admission to appropriately manage safety risks. It should be noted that if a child requires this form of care for a period it is not an automatic indication that they need to be transferred to a specialist acute child and adolescent mental health unit. Referral processes can differ across the state, however if an ADHC case manager believes that a child or young person may benefit from inpatient assessment or treatment, this should be discussed with staff of the local community Child and Adolescent Mental Health Service (CAMHS).

Older people

Older people will generally have their NSW Health provided mental health treatment and support needs met by specialist Mental Health Service for older persons. Referral processes can differ across areas, however in the first instance, referrals by ADHC should be made to the relevant Mental Health service or via the local emergency department. Where possible, specialist consultation can be arranged as necessary.

People from culturally and linguistically diverse backgrounds

Both agencies will ensure that staff members recognise, and planning processes include, the needs and values of service users, their families and carers from culturally and linguistically diverse backgrounds. In order to meet these needs, both agencies should provide cultural competence training for their staff and provide information in languages other than English for service users.

When referrals are being made between the agencies, the service user's cultural background should be noted in the information exchange. This information will assist in the provision of culturally appropriate services, including the use of interpreters and specialist services.

People from Aboriginal and Torres Strait Islander backgrounds

This MOU reaffirms the NSW Government's commitment to working in partnership with people from Aboriginal and Torres Strait Islander backgrounds. Aboriginal and Torres Strait Islander people have the right to:

- A service system that supports the social structure of Aboriginal and Torres Strait Islander communities;
- Have their unique cultural characteristics recognised and valued and are,
- Equal partners in the planning, provision and review of the services provided by both ADHC and NSW Health for people within their communities with an intellectual disability and a mental health illness.

This means that special attention should be given to the provision of information about the service user's cultural background, where the service user identifies as Aboriginal and Torres Strait Islander. Such information will assist in the provision of culturally appropriate services including the use of Aboriginal mental health services and specialist services. Sensitivity in our work with this community is important in building relationships and encouraging people from Aboriginal and Torres Strait Islander communities to access government provided services.

Service users in rural and remote areas

This MOU recognises that people in rural and remote communities have a role in participating in the design and delivery of integrated and flexible services that are responsive to their particular needs.

In rural and remote areas, both disability and mental health services face considerable challenges in being able to meet the needs of service users. In these areas, the joint forums will have a greater capacity for facilitating solutions for service users.

People with a drug or alcohol dependency

Some service users may also have comorbidity issues with alcohol and other drug issues. These service users require services from the drug and alcohol teams within the AHS. As part of the case plan, the disability and mental health services will make a joint referral to the AHS drug and alcohol team. A member of the team will participate in case conferences to develop future case plans for the service user and referral to drug rehabilitation if appropriate.

People in contact with the criminal justice system

People with an intellectual disability are over represented within the criminal justice system. There are currently collaborative practices in place between ADHC & NSW Health in regards to this service user group. These practices aim to improve general community wellbeing and the quality of life of individuals with an intellectual disability/and low cognitive functioning who are in the criminal justice system by:

- Reducing the prevalence of people with an intellectual disability in the criminal justice system by helping them succeed in the community and,
- Ensuring that both agencies and the criminal justice system respond appropriately and equitably to the circumstances of these clients.

Forensic and correctional patients

If a forensic or correctional patient has an intellectual disability and/or requires ADHC services, Area Mental Health or Justice Health should make a referral to ADHC. Corrective Services NSW or Juvenile Justice NSW will also need to be included in this referral.

In the case of young people, referrals to ADHC should be made as soon as possible due to the speed that young offenders move through the criminal justice system. [2] ADHC should liaise with the Mental Health Review Tribunal (MHRT) regarding these referrals.

In the case of referrals for forensic and correctional patients, ADHC should:

- Consider referring any clients who are forensic patients or correctional patients to the Community Forensic Mental Health Service (CFMHS) for an assessment (the CFMHS can assess and provide assistance with mental illness, risk and other medico-legal issues). ADHC could also provide the CFMHS assessment to the next MHRT hearing (CFMHS can also recommend referral to local community mental health services);
- Provide reports for MHRT hearings (including CFMHS reports);
- Inform the treating team or the MHRT if a client is not in compliance with conditions (if conditions include ADHC services);
- Consider joint case conference or regular liaison.

While the Area Health treating team and the MHRT should:

- Let ADHC know of hearing dates in advance;
- Consider including ADHC services within the conditions for release (if both ADHC and the MHRT agree that this is in the person's best interest);
- Keep ADHC staff informed of the person's progress through the MHRT system;
- Make referrals to ADHC if they think the client's needs have changed.

2 The young person is often released before a referral has been accepted. Intellectual assessments should not occur more regularly than once every two years as assessments can be learnt. Previous intellectual assessments can sometimes be acquired from the Department of Education & Training. Adaptive functioning cannot always be measured in detention or correctional centres, as the environment is not the 'normal' environment for the person. Eligibility may be assessed where professional reports consistently indicate intellectual disability. This may be supported either by clinical observations of the individual in custody or in cases of recent arrival into custody, by assessment of pre-entry adaptive functioning based on interview of a significant other.

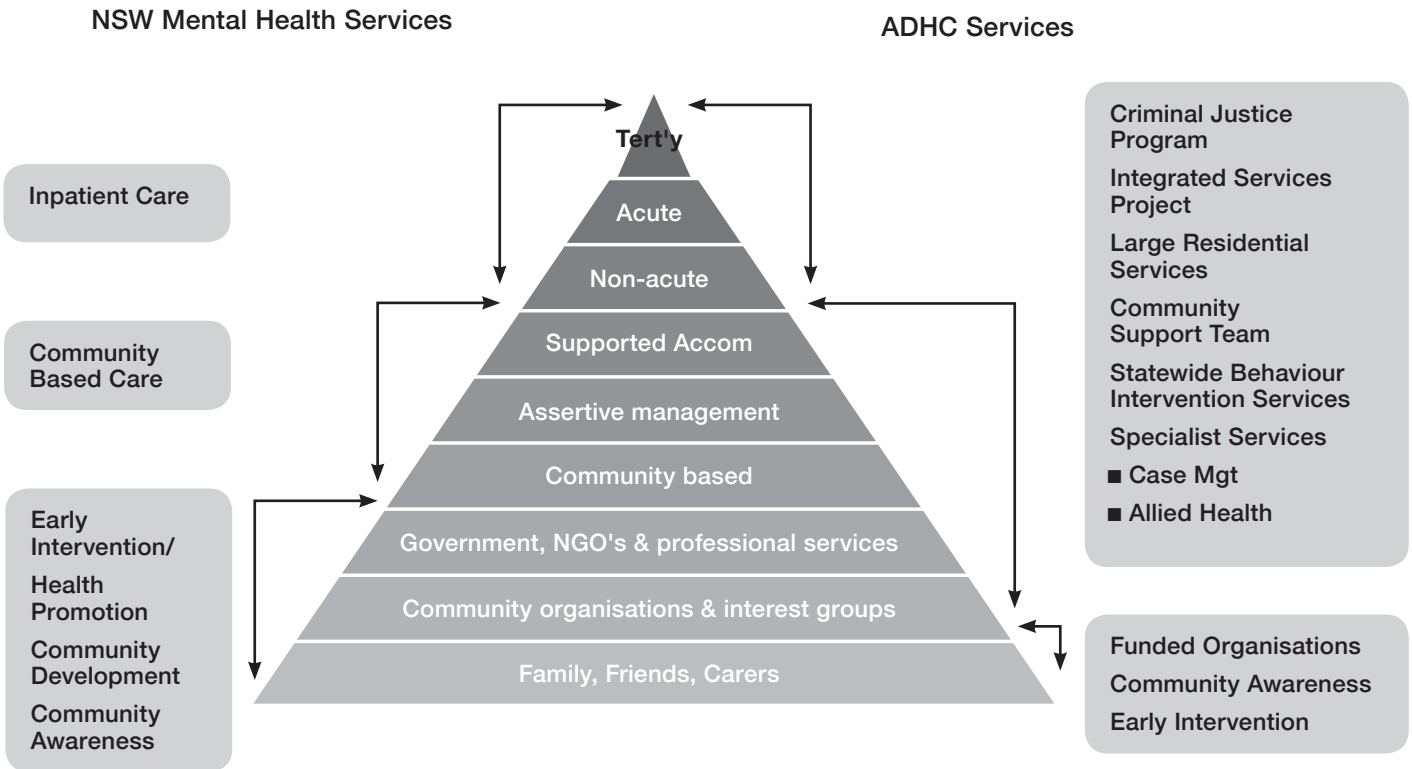
PART F

Research

The MOU endorses the cooperation of both agencies in encouraging and facilitating research that fosters expertise in the area of intellectual disability and mental illness. Research activities will be developed to align with the research agendas of both agencies and will tie in with local area needs. Currently, a full-time University Chair position exists at the University of NSW that is funded by ADHC. The purpose of this role is to provide a focus point for such collaborative research projects.

PART G

Comparison of ADHC and NSW Health Continuum of service



PART H

Map of ADHC Regional and NSW Area Health Service Boundaries

Figure 1. Eight NSW Area Health Services (AHS)*

Figure 2. Six ADHC Regions

Collaboration between:

Ageing, Disability & Home Care (ADHC), Department of Human Services NSW and NSW Health 2010

* Further information regarding the LHNs can be obtained from http://www.health.nsw.gov.au/services/lhn/index.asp.

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