WHAT IS THE CARE COORDINATION MODEL?
The Care Coordination Model emphasises the need for cross-sector collaboration between government agencies, non-government organisations and the private sector in providing support services to individuals with severe mental illness and complex care needs.

The Care Coordination Model aims to improve care planning and increase the continuity of care across service boundaries. The Model also aims to improve service provision by reducing gaps and duplication of services.

CARE COORDINATION STAKEHOLDERS
A Care Coordination stakeholder could be a case manager, a general practitioner, an ATODS worker, or an Indigenous mental health worker. The Care Coordination stakeholder will liaise with and coordinate service provision with case managers, GPs, ATODS, Indigenous mental health workers, and other private health professionals as appropriate. The Care Coordination stakeholder will also liaise and meet with the community service providers and the individual on a regular basis.

A Care Coordination stakeholder can be a non-government organisation employee (NGO), and is normally the NGO providing the highest level of service to the client at that time. This support person will liaise with and coordinate service provision with non-government organisations, other community organisations, i.e. Salvation Army, Greening Australia, etc., other government departments, i.e. Department of Housing, Disability Services Queensland, etc.

The Service Integration Coordinator will ensure a Recovery Plan is completed in collaboration with the Care Coordination stakeholders, the individual, and their family/carer/allied person if requested by the individual. The Recovery Plan will be reviewed on a regular basis (at least 3-monthly) and there will be ongoing communication and meetings between Care Coordination stakeholders and the individual. Participation in the model is voluntary and the individual may disengage whenever they choose.

WHAT IS THE CARE COORDINATION CRITERIA?
Access to Care Coordination will be prioritised for individuals meeting the following criteria:
- have severe and enduring mental health issues
- have complex and multiple service needs.

Individuals must have a combination of the following:
- have multiple support needs such as accommodation, drug and alcohol, employment, community support services, etc.
• require ongoing support to maintain and enhance their personal/vocational/occupational development
• have limited or no family and natural support networks
• have the clinical need, but have not been connected with public/private mental health services or other mainstream health/mental health services
• have high risk of relapse and associated history of multiple hospitalisations, require intensive/assertive case management, and are at greater risk of personal harm
• are more likely to choose not to access services.

WHO CAN REFER?
• Non-Government Service Providers
• MHSG Case Managers
• Indigenous Mental Health Workers
• ATODS Workers
• GPs
• Other Government Departments (DSQ, Housing, Communities, etc.)
• Consumers
• Consumers Family/Carers.

WHAT CAN I EXPECT ONCE THE REFERRAL IS MADE?
The Service Integration Coordinator will be in contact with you to gather any other necessary information and acknowledge receipt of the referral. The Service Integration Coordinator will contact you to let you know whether the individual has been accepted into the Care Coordination model. If accepted, the Service Integration Coordinator will contact relevant stakeholders and provide support to develop the Recovery Plan. If not accepted the Service Integration Coordinator will advise you who the consumer has been referred on to.

HOW LONG WILL IT TAKE?
As referrals are received an anticipated turnaround time of 2-3 weeks will occur. The Service Integration Coordinator will let you know the following day whether your referral was accepted.

HOW DO I GET REFERRED?
You are able to refer yourself to participate in the Care Coordination Model. Talk to your clinical or community care provider, who will be able to assist you in completing the Care Coordination Referral Form and a Consent to Obtain and Release Information Form. You must sign these forms and they will be forwarded to the Service Integration Coordinator for presentation at the next referral meeting.

WHERE DO I FIND THE CARE COORDINATION FORMS?
The following forms and documents are available for use with the Care Coordination model:
• Care Coordination Referral Form
• Care Coordination Consent to Obtain and Release Information Form
• Townsville Care Coordination Model Resource manual.
These documents are available at the following on the Townsville Hospital and Health Service, Mental Health Service Group, Care Coordination Model webpage:

Care Coordination Forms can also be accessed by contacting the Service integration Coordinator:
- Fax: 4433 8144
- Mobile: 0408 078 141
- Email address: Daniel.Clark@health.qld.gov.au

WHAT HAPPENS TO MY REFERRAL?
All referrals are forwarded via fax, email or post to the Service Integration Coordinator who is an independent person who organises the referral meeting and ensures that all referrals received are presented for consideration:
- Fax: 4433 8144
- Email address: Daniel.Clark@health.qld.gov.au
- Postal address: Service Integration Coordinator, Mental Health Service Group, Townsville Hospital and Health Service, IMB 94, PO Box 670, Townsville Qld 4810.

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