

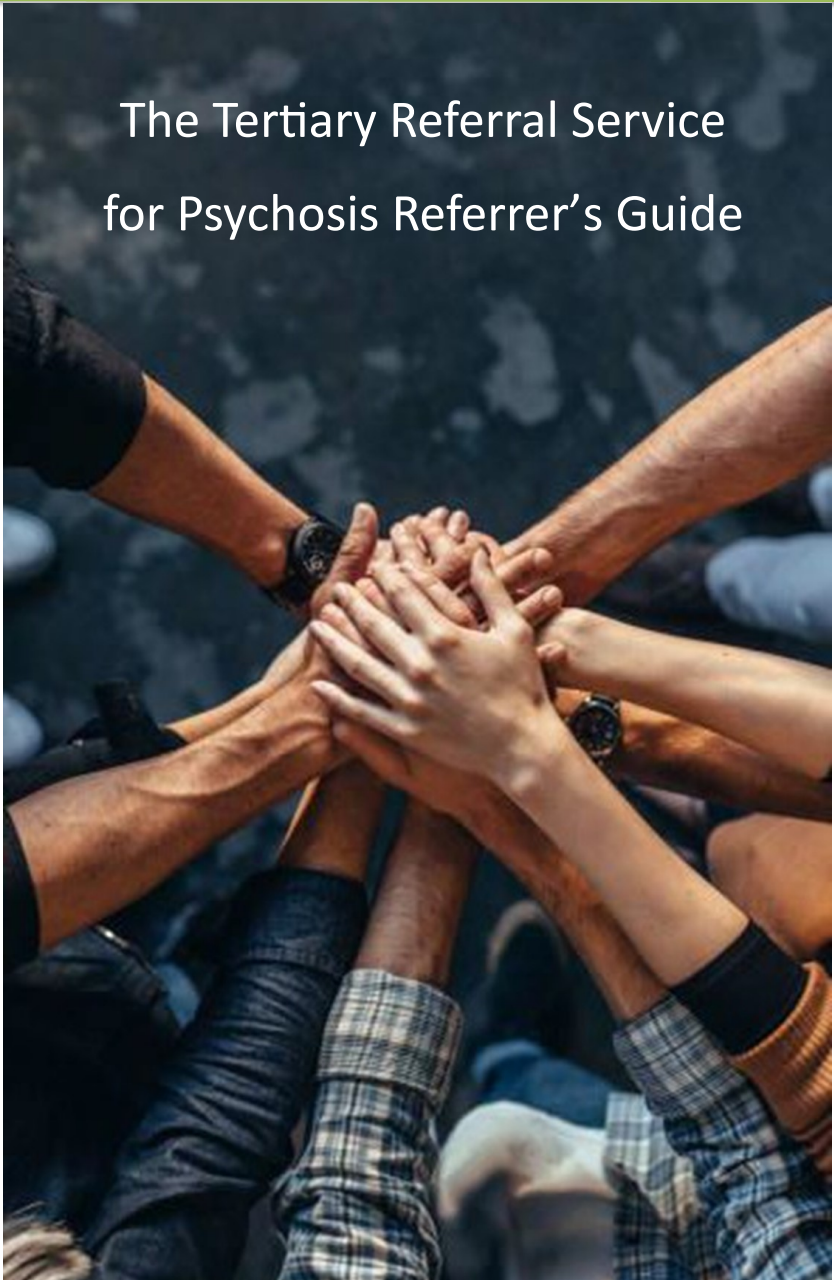


Health
South Eastern Sydney
Local Health District



mindgardens
Neuroscience Network

The Tertiary Referral Service for Psychosis Referrer's Guide





The Tertiary Referral Service for Psychosis (TRSP)

What we do....

- The TRSP is a state-wide service that works with adult community and inpatient mental health teams to improve the lives of those living with complex psychotic illnesses
- Typically, consumers who are referred and assessed by the service are likely to have tried multiple services and treatment approaches, often over many years, without finding support that is truly helpful to them
- TRSP offers intensive and individualised therapeutic approaches for consumers and their families/carers
- TRSP is a consultation and liaison service providing comprehensive multidisciplinary assessment, and collaborative care-planning with consumers, carers, and referring/ treating teams
- TRSP works from a recovery and trauma-informed framework. As we work collaboratively with treating teams and consumers we require expressed consent to engage with our assessment process. We tailor consumer-centred recommendations according to resources available in the individual's own setting
- Following assessment by TRSP the team formulates a series of goals/recommendations which become the basis of a case conference. Post case conference TRSP undertakes collaborative care planning with the consumer, family/carers and treating team culminating in a series of agreed recommendations
- TRSP is underpinned by research evidence. Consumers assessed by the service may be invited to participate in research studies that may be helpful to them. These are optional and do not affect access to the TRSP service
- TRSP is a NSW Health-funded service via Mindgardens Neuroscience Network and hosted by SESLHD. TRSP operates from the Eastern Suburbs Mental Health Service on the Prince of Wales Hospital campus



TRSP Team

The TRSP is a multidisciplinary team consisting of:

- Consultant Psychiatrists
- Psychiatry Registrar
- Peer Support Worker
- Clinical Neuropsychologist
- Senior Social Worker
- Senior Occupational Therapist
- Research Officers
- Administration Support
- Clinical Operations/ Business Manager



Eligibility Criteria:

- Consumer is ≥ 16 years old
- Consumer has an enduring psychotic illness
- Consumer is not currently in a crisis situation (acutely elevated risks)
- Consumer is currently (or will be on discharge from inpatient unit) engaged with an adult community MH
- Referring service understands they remain responsible for ongoing management of client
- Consumer is aware referral is being made and has signed consent form

Reasons for referral may include but are not limited to:

- Diagnostic review and clarification
- High illness burden in terms of severity of symptoms and functional impairment
- Long duration of illness burden in spite of demonstrably adequate treatment
- First onset treatment-resistant illness requiring diagnostic review and management advice
- Rarely used specialised treatments are being considered
- Continuous hospitalisation of long duration
- Failure to respond to an adequate trial of clozapine
- Failure to respond to appropriate psychosocial therapies
- Presence of multiple complicating factors
- Family support/intervention required
- Low/unclear/changed functional capacity
- Self-reported or suspected cognitive or memory difficulties



Assessment Process

1

Referral accepted

New referrals are discussed at either of the 2 weekly intake meetings. A key worker is identified who will coordinate the booking of assessment times. The referring team receives formal notification their referral has been accepted and advised of the assessment process.

2

Information gathering

The team will conduct a file review. You may be asked to provide additional information by members of the team.

3

Multidisciplinary assessment

Assessments will be undertaken by members of the TRSP team, this may be undertaken over several sessions based on the consumer's needs, they can be conducted over telehealth or in person. We may require assistance from your team in the completion or the facilitation of the completion of key assessments

4

Formulation

The TRSP Team meets and discusses the findings of the Multidisciplinary assessments. An issues list is compiled and the items on the list will be the discussion points at the case conference. Identification of experts to attend the case conference.

5

Case conference

This is conducted following assessment and will be approximately 1 hour in length. Case Manager and Consultant are invited to attend this meeting. TRSP will facilitate collaborative discussion with treating team and relevant specialists/external experts.

6

Care planning

This will involve the consumer, any family/carers they would like involved, key members of their treating team and key members of the TRSP team.

7

Report

This is a comprehensive report and provides individualised recommendations, there may be additional reports provided as part of this package.



Referral Form

The TRSP referral form is PDF writable and includes the domains of:

- service and consumer details/ demographics
- key contacts
- history of the consumers journey through mental services
- medical and psychosocial history
- anticipated outcomes of a referral to TRSP for the consumer, treating team and family/ carers

It is appreciated that as much information as possible is included in the referral form; it is difficult and time consuming obtaining a picture of the consumer's journey through mental health services if supplementary documentation is solely provided

If there are any questions regarding referring to TRSP or completing the referral form, please contact the TRSP on (02) 9382 3753.



Date: _____

Received by: _____

Referral Form- TRSP - Tertiary Referral Service for Psychosis

Instructions:

1. Email completed form to: seslhd-pow-trsp@health.nsw.gov.au
2. Once the referral and supporting documentation is received you will be contacted and advised of the referral outcome
3. If accepted our team will work with you to arrange a time and day for assessment.

REFERRER DETAILS

Name: _____
 Position: _____
 Team: _____
 Health Service: _____
 Treating Psychiatrist: _____
 Community Case Manager: _____
 Provider Number: _____
 Phone: _____
 Fax: _____
 Email: _____
 Preferred Contact: Phone Email

CONSUMER DETAILS

Full Name: _____
 MRN: _____
 DOB: _____
 Address: _____
 Phone (H): _____
 Phone (M): _____
 Email: _____
 Interpreter requirement (+ language spoken): _____

Relationship status: Single Married/Defacto Divorced Other

Dependants/children: No Yes – ages: _____

Living with: Alone Parents Flatmates Partner/children Other

Accommodation: Own DOH Rental Family home
 Other: _____

ATSI: Aboriginal Torres Strait Islander Neither

Cultural Background: Australian Other: _____

Employment status: Casual Part-time Full-time Unemployed Other

Financial support: DSP Newstart Savings Family support Other

Current treatment: Outpatient Inpatient: _____

NSW MHA status: Voluntary IPO: _____ CTO: _____
Facility name

Review date: _____



Date: _____

Received by: _____

ELIGIBILITY CRITERIA: *(ensure all criteria are met- please tick)*

- Consumer is \geq 16 years old
- Consumer has an enduring psychotic illness
- Consumer is not currently in a crisis situation (acutely elevated risks)
- Consumer is currently engaged with a community MH team
- Referring service understands they remain responsible for ongoing management of consumer
- Consumer is aware this referral is being made they are agreeable

REASON FOR REFERRAL: *(tick all that apply)*

- Diagnostic review and clarification
- High illness burden in terms of severity of symptoms and functional impairment
- Long duration of illness burden in spite of demonstrably adequate treatment
- First onset treatment-resistant illness requiring diagnostic review and management advice
- Rarely used specialised treatments are being considered

Please specify: _____

- Continuous hospitalisation of long duration
- Failure to respond to an adequate trial of clozapine
- Failure to respond to appropriate psychosocial therapies

Please specify: _____

- Presence of multiple complicating factors

Please specify: _____

- Family support/intervention required
- Low/unclear/changed functional capacity
- Self-reported or suspected cognitive or memory difficulties

NOK DETAILS:

Full Name: _____
 Relationship to client: _____
 Address: _____
 Phone (H): _____ (M): _____
 Email: _____
 Emergency contact (if different): _____ ph: _____

KEY CONTACTS:

- Public Guardian: _____ Other Guardian: _____

Name and details:

functions:

- Financial Management Order: _____

GP: _____

Psychologist/counsellor: _____

Private Psychiatrist: _____

Medical Specialists/Services: _____

Alcohol & Drug Services: _____

NGO involvement (HASI, EACLS, other): _____

NDIS: Yes No Application in progress Assistance required

NDIS Plan review date (if known): _____

NDIS Support Coordinator & Organisation: _____

Contact details: _____

Other support organisations involved: _____

Support worker name: _____

Contact details: _____

Frequency of current supports: _____

Services provided: _____



Date: _____

Received by: _____

BRIEF SUMMARY OF PSYCHIATRIC HISTORY AND CURRENT SYMPTOMS:

Psychosis diagnosis: _____

Other Psychiatric Diagnosis and/or Substance Use: _____

Hospital Admission Location Sites: _____

BRIEF SUMMARY OF MEDICAL HISTORY

BRIEF SUMMARY OF PSYCHOSOCIAL HISTORY

CURRENT & PAST RISK ASSESSMENT

Please provide details of any significant history of self-harm, suicide, aggression, etc. and any precautionary measures (if any)

FORENSIC & LEGAL HISTORY

Please provide details of any previous charges or incarceration and dates (if available), any forensic orders, AVOs, current probation/parole or conditions, ongoing legal issues, previous forensic assessments.



Date: _____

Received by: _____

LIST OF CONCERNS & CURRENT ISSUES RELATED TO CARE:

Service provider's concerns: _____

Consumer's concerns: _____

Support/carer concerns: _____

SUPPORTING DOCUMENTS AND ATTACHMENTS

If these are not accessible to us via the SESLHD EMR system, please include copies of the following if available:

- Current medication grid/list
- Most recent blood test results (including standard bloods, metabolic bloods, therapeutic drug monitoring levels, organic screening, antibodies, etc.)
- Previous neuroimaging results and reports
- Recent MH assessment (A1) or Tribunal Report etc.
- Previous psychiatric inpatient admission/discharge summaries
- Specialist Risk Assessments (HCR-20, CRAM) or Forensic Assessment
- Neuropsychological Assessment
- Cognitive Assessment/screening
- OT functional assessment
- Current NDIS Plan
- Consumer Wellness Plan/Relapse Prevention Plan
- Recent Strengths Assessment

Action taken: Referral is accepted Referral is inappropriate

Date presented to intake meeting: