



METRO HOME LINK (MHL) SERVICES FOR MENTAL HEALTH CLIENTS SOUTHERN REGION GUIDELINES

Metro Home Link is a SA Government service that provides short term support and assistance for people in their homes, including residential care facilities, to avoid unnecessary visits to the emergency department, admission to hospital, or to assist patients to leave hospital earlier than otherwise would have been possible in a safe and supportive environment.

Home Support Services Pty Ltd (HSS) is responsible for providing Metro Home Link Services

TYPE OF PACKAGES AVAILABLE

MHL offers a range of services which can be accessed for Mental Health clients:

1. Hospital inpatient wards can refer for discharge packages.
2. GPs, Emergency Department or mental health key workers can refer for hospital avoidance packages.
3. Services within SAHS can also refer for peer support packages, which can offer assistance on discharge to consumers with limited social supports.

PRINCIPLES OF PACKAGE APPLICATION

- MHL packages aim to achieve **immediate** hospital substitution for Emergency department presentation, hospitalisation, facilitate an early discharge, or reduce the immediate risk of readmission. They are not intended to be a substitute for normal discharge planning.
- MHL provides short term, rapid, flexibly responsive services
- The standard package is provided, in the majority, for up to 7 days but some flexibility exists for both intensity of resources applied during the 7 days or extended timeframe
- MHL is one part of longer term plans that should be in place for any client
- MHL cannot provide interim care, but can be used to bridge to other services, and MHL will refer on to other community services when required
- MHL is not intended to be a substitute for normal discharge planning

HOW TO REFER

To refer to Metro Home Link or to make any enquiries call the Coordination Centre on 1300 550 654 or fax the referral on 83724888 **AS PER BELOW CHART.**

All packages are coordinated through this centre.

WHAT AND HOW ARE SERVICES PROVIDED?

Home Visiting	Support workers can make visits to check the client's welfare, provide structure to a client's day, and give support.
Shopping Support	Consumers report the difficulty with poor concentration, and decreased energy when unwell, making tasks such as shopping and preparing meals difficult. A care worker can be arranged to assist with shopping, and ensure that there are supplies in the home during this period, or assist a client regain skills on return from hospital.
Transport Support	During the period of the acute exacerbation more journeys may be required to escort patients to therapy sessions and specialist reviews. Having a care worker do this task can free up a key workers time to do much needed clinical tasks, while still ensuring that patients attend the reviews required.
Personal Care Support	This can include washing clothes and assistance about the home. The patient may be limited in their ability to do this because of poor energy, or disorganisation. There may be a combined effect of being psychiatrically unwell, with other physical illnesses or injuries. Metro Home Link can provide this acute assistance regardless of the cause.
Respite Accommodation	Accommodation can be provided for up to one week.
Provision of Specialist Service	Physiotherapy and other specialist allied health input. Metro Home Link will provide these services e.g. for patients with co morbid conditions (e.g. a patient who has depression and chronic pain).
Childcare & After School Care	This may provide some respite for an unwell parent.
After hours Support	This needs to be initiated in hours. Structured visits and welfare checks can be arranged as required on weekends, at times.
Provision of Meals	For patients unable to shop, and prepare an adequate meal during an exacerbation, meals can be arranged by Metro Home Link.
Supervision of Medication	Patients with co-morbid conditions who may require regularly intravenous or intramuscular injections can have this input through Metro Home Link. If required oversight of oral medications can be arranged (e.g. having a staff member in attendance to remind the patient to take necessary oral medications, and to be present when they do.)
Overnight Oversight	A care worker can be provided to be present overnight if required.
Carer Respite and Support	To provide time out for carers of this acute period, by offering an alternative source of support and supervision for a client.

First General Practitioner Visit

May be required for a physical GP check up during an acute exacerbation or, a first GP visit post discharge. Assistance with arranging appointments, introduction and transport to a General Practitioner.

Taking Patients Home on the Day of Discharge

Including transport home, and ensuring adequate resources are in place for the post discharge period.

Top up Hospital in the Home

Daily nursing visits from Hospital @ Home, may if required need to be topped up by a care worker visit, and Metro Home Link can also arrange a nursing visit (from a general trained nurse) as required.

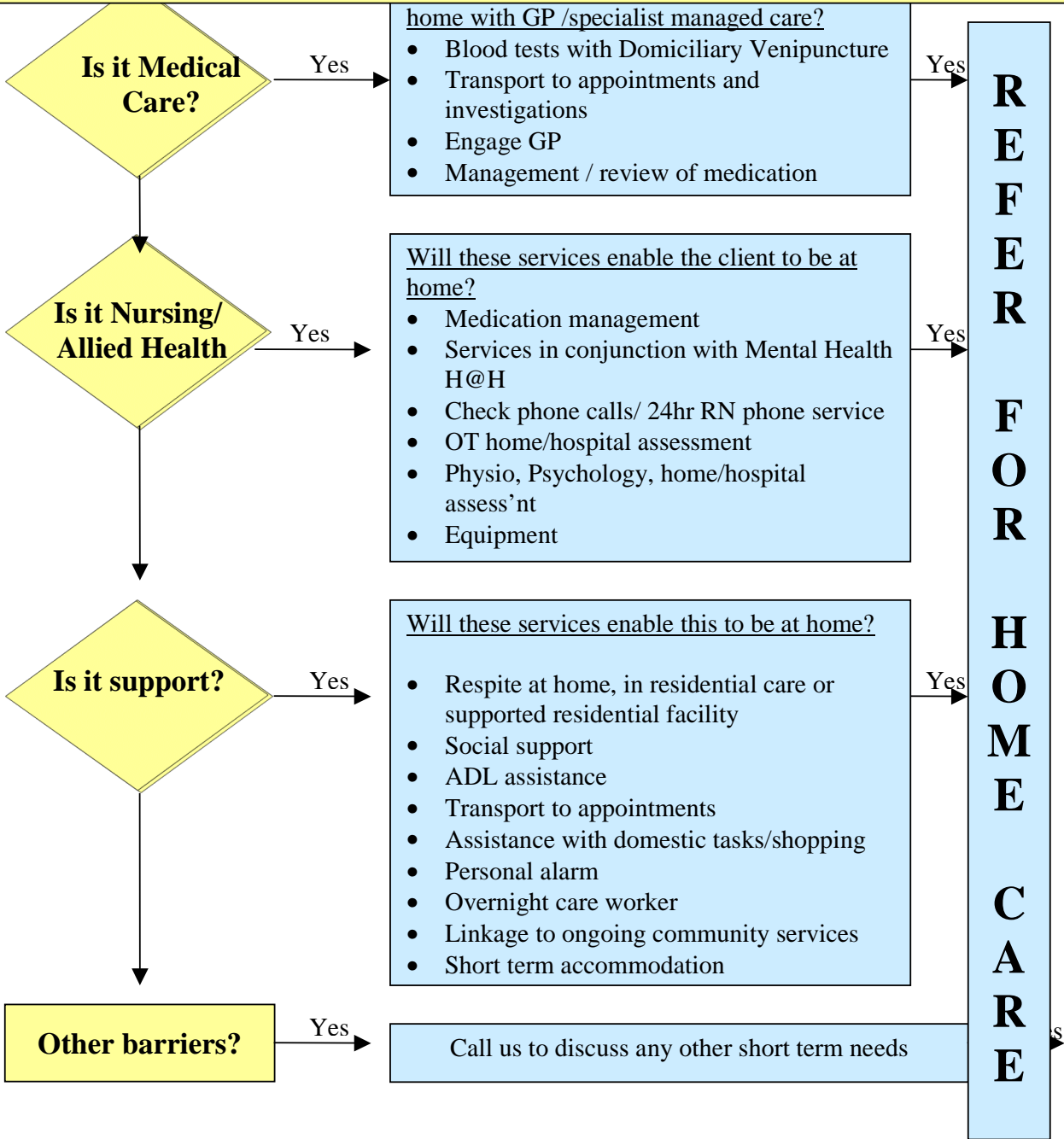
Peer Support Programme

2 weeks support post discharge by peer worker. Appropriate for clients with limited social supports. May include phone support, home visits, accompanying clients to GP appointments, assisting clients to go shopping or pay bills, respite for carers/family, assistance with meal preparation or transport home from hospital.

The Home Care Indicator for mental health clients is also attached.

Mental Health Home Care Indicator

What services will enable the client to avoid hospital or/reduce their stay?



**METRO
HOME
LINK**

1300 550 654

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Hospital Provider 0067090F
ABN 59 008 193 100

REFERRAL FLOW CHART

Call 1300 550 654
24hrs 7 days
for referrals & information
OR

MHL Referral form required for ALL CLIENTS
(unless referral is phoned)

Mental Health Referral form for Mental Health clients

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Medication Authority if client requires medication to be administered by a nurse

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Anaphylaxis Treatment Protocol if client requires IV Therapy or IV/IM antibiotics

Central Case Coordination
Multidisciplinary team of experienced Case Coordinators, including Occupational Therapists, Social Workers, & Specialist RN's (*midwifery, paediatrics, acute care, mental health and residential care*) will plan & manage the delivery of individual patient care.

Care provision

- On completion of care patient is discharged & summary sent to referrer and GP
- Linkages to ongoing services are organised as required

Please note that a **GP Signature** is required for all hospital avoidance packages, except for Mental Health and referrals from Residential Care.