2.3 COLLABORATION AND CASE MANAGEMENT

MELISSA KANG

Collaboration occurs when service providers develop internal and external working relationships with other agencies that share similar service goals and target groups. Actions include communicating, networking and working together, both within and beyond the service's immediate sector (e.g. health, education, welfare, drug and alcohol, recreation)
Youth Health Better Practice Framework (2012)

Collaboration can occur at the level of individual health care, or at a service or program level. It is important because optimal health care is achieved when clients and health care providers work together to achieve health goals. Implicit in this is the understanding that health is a state of wellbeing in physical, mental and social domains.

SOME DEFINITIONS

Before looking more closely at practical collaboration in health care, it is worth defining three key terms that we will be using.

HEALTH CARE:

- Refers to general and specialist medical care; nursing; psychological and other mental health care; and allied health care (e.g. physiotherapy, dietetics, occupational therapy).
- It can be delivered through primary care, secondary or tertiary care (see chapter 2.1 for descriptions of primary, secondary and tertiary care). These are known as clinical services.

HEALTH CARE SUPPORT:

- Refers to people or services that help young people to access health care, or that provide advocacy or assistance to optimise the health care that is provided to young people.
- It can be highly practical (e.g. providing transport to appointments or paying for health services, medications or other treatments for the young person), or less tangible (e.g. encouraging a young person to seek health care or to adhere to treatment; providing opportunities to 'debrief' or discuss health care).
- Advocacy might involve negotiating on a young person's behalf for appointments or cost reductions.
- Health care support can be provided by workers within and outside the health care system or by families and carers.

HEALTH PROMOTION:

- Refers to both the formal activities undertaken by health promotion workers in the health system and to a range of activities that can be provided by clinicians, educators and workers outside the health system.
- It involves not only providing health related information to young people but also actively seeking their participation and increasing their capacity to care for their own health.

UNDERSTANDING COLLABORATION

The 2005 Access research project (NSW CAAH 2005) identified collaboration as one of the seven principles of better practice in youth health.

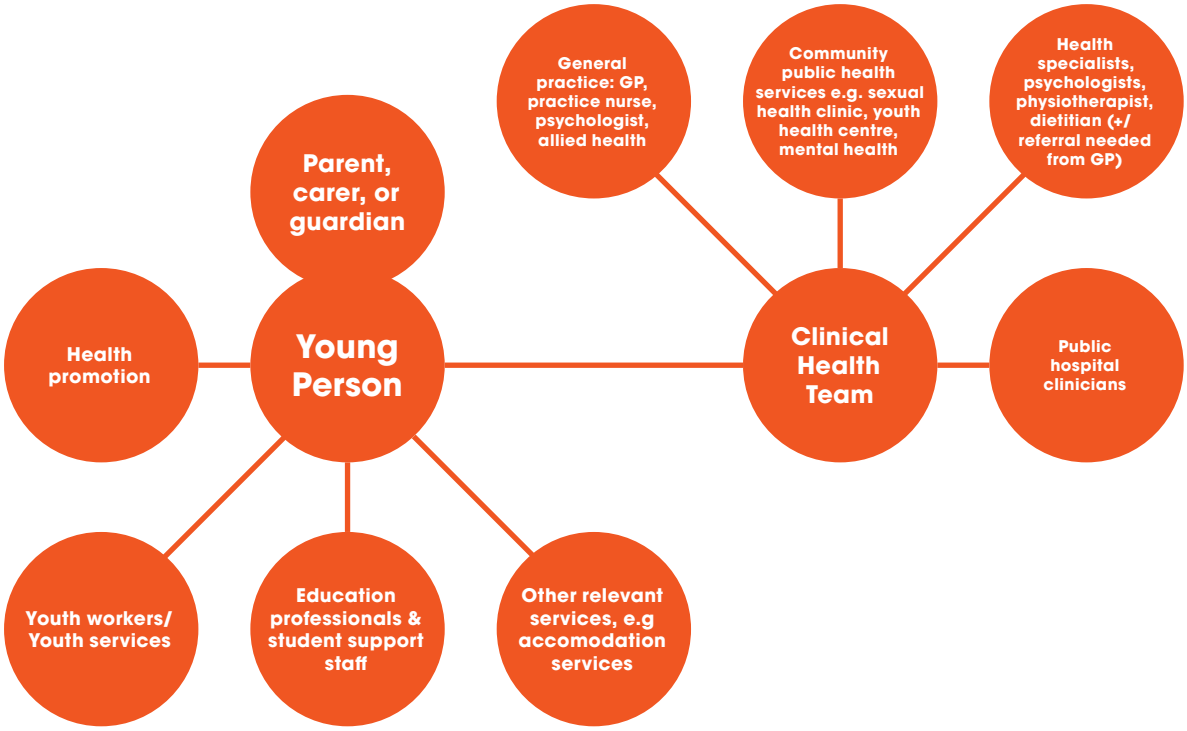
It can occur informally or formally, but always requires commitment, an attitude of cooperation, and often considerable practical time and effort. In fact, many health care and other service providers find working collaboratively with other services more challenging than the specific clinical challenges that arise from working with the young people themselves. Specifically, the Access project found that service providers working collaboratively faced challenges in:

- Successfully referring young people to other service providers
- Negotiating service pathways
- Experiencing a lack of partnership
- Feeling the pressure on services to fill service gaps
- Creating sustainable inter-service collaboration rather than ad hoc systems.

This study found that, for practitioners, collaboration involves:

- Planning
- Knowing when to refer
- Sharing information
- Exercising judgment
- Negotiating between service systems

Figure 1: What does a 'health care and support team' look like?



COLLABORATING IN PRACTICE

The process of collaborating in providing health care to a young person often evolves over time, but it usually begins at an entry point, where a young person seeks or accepts an offer of a health assessment.

Young people reach a health care entry point in a variety of ways: it might be a critical event (e.g. an acute injury, severe suicidal thinking, a sudden and serious medical illness, an unexpected positive home pregnancy test); short or longer term non-critical un-wellness (e.g. a head cold that appears to be getting worse instead of better; low back pain of a few weeks duration; tiredness or lethargy lasting a few weeks; feeling depressed or anxious over a prolonged period; concerns about weight loss or weight gain); or it might be preventive in nature (e.g. seeking advice about contraception; seeking advice about quitting smoking; getting a Pap smear).

Parents or carers often facilitate young people's access to health care and might even accompany them to appointments. If a young person does not live with a parent or carer, or does not wish for their parent/carer to know about their health concerns, they might benefit from the support or encouragement of a friend, another adult in their life, or a service provider such as a youth worker. Regardless of which adults or peers assist the young person to access health care, it is important for all parties to understand the young person's rights to confidential health care.

The arrival of a young person at one of these entry points offers a unique opportunity to begin a collaborative process of health assessment and care.

Collaboration occurs through planned and cooperative arrangements between young people, their families or carers, and workers within and outside the health care system.

UNDERSTANDING ROLES

For collaboration to work effectively, it is important to identify the key roles of different members of the health care and health care support teams. Even if the roles are not written down, it is useful for each person to have an understanding of their responsibilities.

Some collaborators will have several roles. For example, a clinician – such as a counsellor, doctor or nurse – might also provide health education and undertake advocacy on behalf of the young person (such as writing support letters to the school or the Board of Studies, or to Centrelink, or the Department of Housing). A youth worker might facilitate access to health care as well as advocating for a young person at their school.

Roles for health care support workers (non-clinicians) may include:

- Providing support to meet basic needs (e.g. helping the young person to find accommodation, food, facilitating access to income support)

- Providing information about health issues and health services
- Facilitating access to health care at all levels (through practical support or encouragement to seek health care by discussing barriers and explaining how they might be overcome)
- Providing informal supportive counselling – including debriefing about experiences with health services and listening to the young person's concerns
- Advocating on behalf of the young person to negotiate health care appointments, services and costs.

For effective collaboration, there must be clear goals, with the young person at the centre. In meeting those goals, there may be roles for several individuals, services and sectors to be involved in the health care of a young person, particularly if their holistic health care needs are complex. A young person's needs will change over time (sometimes very quickly) and thus, so will the appropriate service responses.

COLLABORATIVE CARE AND MEDICARE

GPs can play an important role in coordinating collaborative care by using Medicare item numbers to initiate multi-disciplinary shared care with other health professionals, specialists and youth services.

However, young people can be reluctant to visit GPs or engage in the health system. They may be worried about confidentiality and privacy, or may not have sufficient money to pay for a visit to a non-bulk billing GP.

Youth service providers can support and encourage young people to visit a GP by:

- Discussing the reasons for referral to a GP with sensitivity and clarity.
- Letting young people know that they can apply for their own Medicare card once they are 15 years old.

The Medicare system has a range of item numbers that GPs can use to provide collaborative health care to young people. These item numbers facilitate:

- Mental Health Care Plans to see a Psychologist or Psychiatrist
- The treatment of chronic conditions such as asthma and diabetes
- The provision of allied health care
- Referral to specialists

FINDING OUT MORE...

Learn more about communicating effectively with young people in chapter 3.1 Youth-friendly communication. You can also learn more about confidentiality in chapter 3.5 Medico-legal issues for information about confidentiality. Find out more about Medicare at www.medicareaustralia.gov.au/provider

KEEPING THE YOUNG PERSON 'CENTRE-STAGE'

As young people move through adolescence, they increasingly seek more autonomy and independence. This can require practitioners to recognise and balance the young person's increased capacity and desire to make their own decisions about their health with the relationship between the young person and their parents or carers.

The physical, cognitive and social changes that occur as part of natural development are legally recognised: young people under 18 years can consent to their own treatment without parental consent if they are competent. Even when parents are closely involved in a young person's health care, it is important to place the young person's needs at the heart of health care considerations.

FINDING OUT MORE...

Learn more about consent and competence to consent in chapter 3.5 Medico-legal issues.

WORKING COLLABORATIVELY WITH PARENTS AND CARERS

A challenge for service providers in working with the young person is to gauge the desired or required level of involvement of a young person's parents or carers– particularly if the young person presents by themselves or does not want their parents involved. Whenever it is possible and appropriate, discuss with the young person the level of involvement they want their parents or carers to have.

Decisions about the level of parental or carer involvement depends on a number of factors:

- The age and developmental stage of the young person
- The nature of the relationship between the young person and parent(s)
- The nature of the presenting problem – parents may need to be involved where major health issues are concerned (e.g. unplanned pregnancy, prescription of medications, suicidal behaviour); or when dealing with problems where the family will play a major role in supporting or implementing the management plan, such as eating disorders, obesity, and mental health disorders.

Where possible, make a collaborative decision after discussing the pros and cons with the young person. While you have a duty to maintain confidentiality, you can still encourage and assist a young person to talk to his or her parents about important issues.

Be sensitive to the concerns of parents from cultural backgrounds where health care may be viewed as a private or family matter. Where possible, respect their wishes and rights to be involved in their adolescent's health care.

BUILDING RELATIONSHIPS FOR COLLABORATION

BUILDING RELATIONSHIPS	AVOIDING PITFALLS
Communicate effectively and regularly with other health care team members	Allocate time in your diary to write correspondence, attend meetings and engage in other strategies that will enhance collaboration
Trust in the expertise of other health care team members	Rather than discouraging a young person from following advice, facilitate the young person's understanding and health literacy by helping them gather information
Trust in the capacity of the young person to comprehend what's being offered and to make their own decision	Rather than imposing yourself into the decision making process, facilitate and advocate for the young person if they seem to be struggling
Appreciate that there can be different approaches to the same health issues (e.g. harm reduction vs. abstinence in substance use management)	Rather than being critical of one approach and promoting another, help the young person learn about what these differences are and what works when and for whom

WHO CAN YOU COLLABORATE WITH?

To put you in the best position to provide youth-friendly collaborative health care, start establishing a referral network of services in your local area. Some services you might join with include:

- Youth workers
- Adolescent mental health service
- Psychiatrists
- Psychologists, mental health nurses, Social Workers and other counsellors
- Drug and alcohol service
- Community health centre
- School nurses or counsellors; student welfare coordinators
- Youth accommodation services
- Department of Community Services
- Family planning/sexual health service
- Transcultural Mental Health Centre
- Bilingual Counsellors in mental health teams
- Other CALD-specific services
- Aboriginal health services
- Refugee health services

FINDING OUT MORE...

In some situations, finding the balance between the young person's wishes and the parents or carers wishes may take some skill. For more information, see chapter 3.13 Working with families.

WHAT IS CASE MANAGEMENT?

Case management involves the dual dimensions of comprehensive (holistic) care and continuity of care. It involves a cycle of assessment, care planning, management, monitoring and review but also includes care facilitation, care coordination and advocacy. Underpinning all these activities is the element we have just reviewed – collaboration.

WHO DOES IT?

Case management can be either informal or formal. Many people accessing health services act as their own case managers – they look for the services they need, collate and filter information from a range of providers and sources, arrange their own access to care and advocate on their own behalf. They collaborate with health providers for particular issues such as deciding on management plans or agreeing to receive reminders about monitoring their health, but they manage their own 'case'.

In some cases, an individual's health needs become more complex and they require the expertise of multiple providers and services. In other cases, a person has certain vulnerabilities that limit their ability to seek, receive or coordinate care. In these cases, formal case management becomes a powerful and supportive process for optimising health care. Some services have Case Managers who are identified by that role, while others have individuals who perform case management without a formal title.

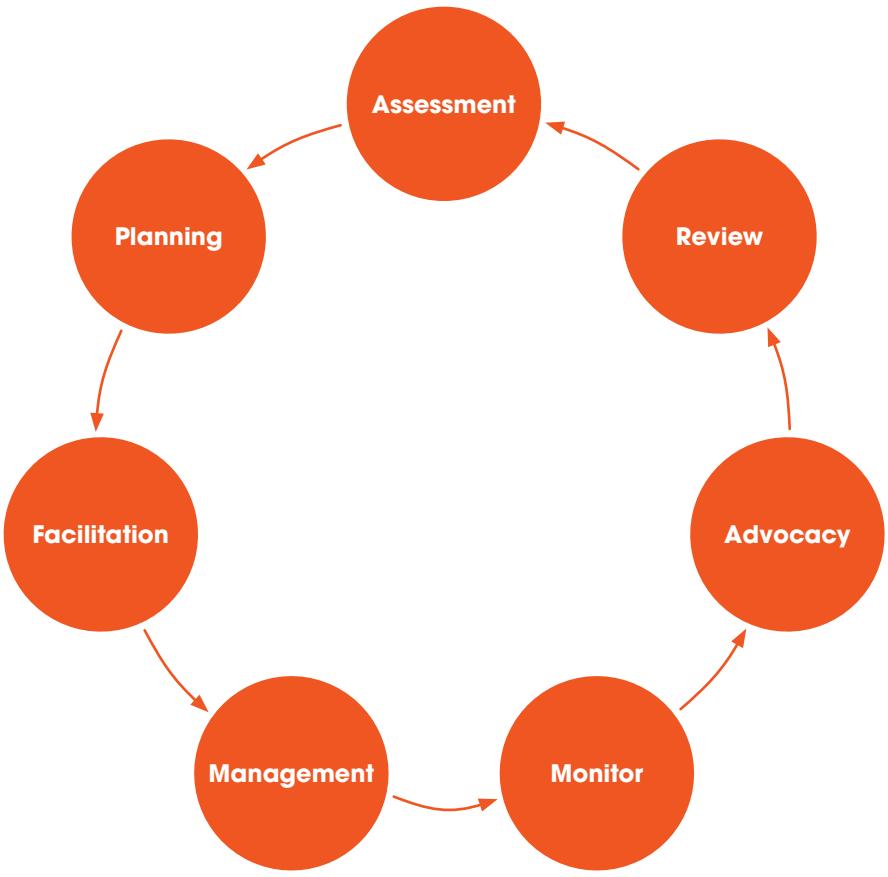
The concept of assertive case management adds to these elements by emphasising the importance of engaging closely with clients (who might be reluctant or resistant) and following- up when a client's engagement with services is fragile.

In the Australian health system, general practitioners often fulfil the role of 'case manager' for many of their clients. This is often the case for clients with chronic conditions who require both primary and secondary health care services involving medical and surgical specialists and allied health staff. Young people with chronic conditions will often have a health care team. Case management might occur informally by the GP or paediatrician. A young person with insulin-dependent diabetes, for example, will often have a GP, diabetes nurse educator and paediatrician/ endocrinologist on their health care team.

Young people with complex health issues where there are compounding factors such as psychosocial stressors (e.g. homelessness, social or cultural issues impacting on health, mental health or substance use issues) often come into contact with services in different parts of the health system that historically have not worked collaboratively (e.g. GP, youth worker/ youth service, mental health staff from education sector or mental health sector). There are times when formal case management might be beneficial in improving collaboration and therefore health care.

Case management generally moves through seven steps; however, at any time it may be necessary to revisit one or more steps. For example, a change in living arrangements for a young person may require a re-assessment of their needs. A change in their health status (for example, a period of hospitalisation for a chronic condition) may require the management plan to be reviewed. The process is fluid and must respond to the needs of the young person.

Figure 2: Seven Steps of Case Management



CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT MEENA

Meena has just moved into a medium term youth refuge. The refuge accommodates up to 6 young women aged 16 and 18 and has one staff member on site 24 hours a day and one manager during business hours.

Meena is 16 years old. She was born in Australia and has grown up in a socio-economically average suburb in a capital city. She is of Indian heritage and speaks English at home, although she understands some Hindi which is her parents' native language.

Meena has been living with her parents and older brother but has just moved into a medium-term youth refuge after an unstable 3 month period of living between friends' houses. She is in Year 11 at a high school that she used to walk to from home.

The school counsellor and student welfare officer referred Meena to the refuge after Meena missed several days of school and was late on many occasions in the last 3 months. The refuge is 5km away from the school and she has to take a bus.

Meena's father has a long history of alcohol abuse and becomes verbally abusive to all members of the family when he has been drinking. He has occasionally been physically abusive towards Meena's mother. Meena's 20 year-old brother has also started drinking quite heavily and can also become verbally abusive. Meena's mother does not drink but has been emotionally abusive towards Meena. She tells Meena that she is the reason her father drinks so much; that Meena does not help enough around the house; and that she wants to spend too much time out with her friends.

Meena is very quiet and is often teary. She has been going to school but is looking tired. She does not appear to be eating much, and although is talking with the other young women a little she is mostly withdrawn.

PLANNING – IDENTIFY MEENA'S NEEDS

Basic needs

The school notified Community Services one month ago because of Meena's homelessness. Community Services has not allocated a case worker because medium-term accommodation was found and adequate shelter was available.

Meena applied for Centrelink youth allowance with the assistance of staff at the refuge.

Educational / occupational needs

Meena is continuing to go to school and intends to complete Year 12. The school counsellor is now trying to engage with Meena.

Health needs

You have concerns about mental health given her background, and because she seems withdrawn and has been teary. She appears pale and tired but looks otherwise physically healthy. As part of her intake information you know that she does not have a regular GP and has not seen any counsellors or other health professionals. She does not have her own Medicare card but staff at the refuge are trying to assist her to obtain one.

Social and cultural considerations

Meena says she identifies as Indian-Australian and has previously enjoyed some of her family's traditions. She has always eaten Indian food at home which her mother cooked and is vegetarian. She has some Indian cousins who live in the city as well. Although there are no major financial pressures on the family, she says her father's job as a bookkeeper in a small accounting firm is very stressful. Her mother works part-time as a retail assistant.

Her school friends come from various cultural backgrounds but most are Anglo-Australian. Since moving out of home, Meena has found it difficult to keep in contact with her group of friends outside of school hours as she now lives further away from her social supports.

KNOWING WHEN TO REFER

Young people who become homeless and/or who have experienced abuse or neglect have higher rates of health problems for a variety of reasons. A comprehensive health assessment that includes exploring physical, mental and social health can help identify health issues that might be responsive to health interventions, and can provide an opportunity for preventive health measures to be put in place to support Meena.

Referral for a comprehensive health assessment is ideal if Meena is willing.

EXERCISING JUDGMENT

Meena initially says she does not want to see a counsellor or a doctor. But with her permission, staff at the refuge communicate with the school counsellor once or twice a week and work collaboratively with the counsellor to support Meena as she settles into the refuge and her new living arrangements.

After the first week, one of the staff at the refuge spends some time chatting with Meena and moves on to asking her how she is sleeping and what her appetite is like. This gives the worker the opportunity to suggest that a health check might be useful, since Meena reports having difficulty sleeping. The worker talks with Meena about options (which include a GP, a headspace centre and a youth health service) and tells her about confidentiality.

After another week, Meena agrees that she would like to talk to a doctor about her sleeping problems. Together, they make an appointment with a headspace GP who has seen young people from the refuge previously.

SHARING INFORMATION

Meena has signed a consent form for staff at the refuge to communicate with her school counsellor and Centrelink. Meena wants to avoid having to retell her story as much as possible and agrees for information to be exchanged with staff at the headspace centre. The refuge staff and the school counsellor have both explained the facts about information sharing, and the limitations on confidentiality when there is concern for a young person's immediate safety or wellbeing.

NEGOTIATING BETWEEN SERVICE SYSTEMS

The staff member at the refuge offers to support Meena by going with her to the headspace GP appointment. Meena expresses relief to have someone familiar go with her. The staff member lets Meena know that if there is something she wants to discuss in private with the GP then this is also ok. Meena and the refuge staff contact Medicare to get her Medicare number and expiry date to give to the headspace centre while her application for a card is in process.

PROGRESS OVER TIME

Initially, Meena is happy to see the GP and have a medical assessment. She sees the school counsellor irregularly as she skips many of her appointments. She does not want formal 'counselling'. She opens up a little to one refuge worker in particular and talks about her family and her friends.

After 2 months though, Meena seems increasingly depressed. She attends school regularly but is not keeping up with school work. Her mother calls her occasionally and Meena always seems more withdrawn after these contacts. The refuge worker expresses their concern about Meena's wellbeing and asks Meena how she is doing. Meena admits to feeling sad and depressed most of the time. She is still not sleeping well.

The refuge worker explains that there are health professionals who may be able to help Meena, including the GP she saw. The worker reminds Meena that she does not have to undergo any 'treatment' that she doesn't want to and has the right to choose, but that she might wish to explore the options in more detail. The worker explains that while they can provide support to her, she may need other people to help address health issues.

After another 3 weeks, Meena agrees to see the GP at headspace again. The GP is concerned that Meena is depressed, but assesses that she is not at risk of suicide, nor is there any self-harm. The GP explains that formal counselling can be an effective treatment and suggests that Meena could see one of the psychologists at headspace.

The GP also knows that other supports are equally important, including safe and stable accommodation, school support and possibly facilitating some communication with the family. After conversations with the school counsellor, the GP and refuge worker both write support letters to the school as Meena has received cautionary letters for incomplete assessments.

CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT TYLER

Tyler is a 14 year-old Anglo-Australian boy living in a regional town in NSW. He has started attending a youth centre after school once a week. He discovered the centre while walking home from school one day. He lives at home with his mother and 2 younger half-sisters who are 3 and 5 years old. His dad lives about three hours away in another large regional town and Tyler sees him once every couple of months. Tyler is in Year 8 at the local high school. Tyler is overweight and occasionally seems a bit short of breath when he arrives at the youth centre. He also appears to have a rash on his hands and arms that you have noticed him scratching.

PLANNING: IDENTIFY TYLER'S NEEDS

Basic needs

From informal conversations with Tyler, you have determined that Tyler feels safe and loved at home, and feels close to his mother and half-sisters. He would like to see more of his father but knows that geographical distance is the main problem. He is not close to his stepfather, who is now separated from his mother. Tyler's mother is on a Centrelink benefit and struggles financially but there seems to be adequate shelter, food and clothing.

Educational/ occupational needs

You also ascertain that Tyler has no major problems with his school work or with teachers and has a few friends at school. He does get teased by some other kids about his weight but says he has dealt with this 'all his life'.

Health needs

You have some concerns about Tyler's physical health. At this stage you are not sure about health risk behaviour or mental health issues. Tyler does have a family GP who you happen to know does not routinely bulk bill. He has not been to the GP in the last 12 months.

Social and cultural considerations

Tyler has always lived in this region. His parents separated when he was eight and his father moved away. His father works for a local council. He has since re-partnered and has 3 stepchildren. The students at Tyler's school are mostly Anglo-Australian, although there are some Aboriginal students and a small number of students from CALD backgrounds. Many students are from a socio-economically disadvantaged background. Tyler sometimes feels 'different' because he is overweight.

KNOWING WHEN TO REFER

Because you have observed physical symptoms and Tyler has told you he has a GP that he has not seen in 12 months, you would like to facilitate a health assessment. You also have concerns that his weight is a source of physical and social distress for him.

EXERCISING JUDGMENT

Tyler has expressed some hesitation about addressing his health needs at present. He is worried that his mother won't understand his concerns. Tyler has agreed to continue to see you at the youth centre to find out more information about the support available so that he can make a decision.

SHARING INFORMATION

You have discussed consent and confidentiality with Tyler and how this affects his medical care. You feel that he would benefit from involving his mother in his health care. Tyler says he would like his mother's support in getting his weight under control, but he doesn't feel confident in talking to her about this. He has asked for some help explaining to his mother how difficult things have been for him and how he has been bullied about his weight. He is also troubled by his breathing difficulties and his rash; sometimes these keep him awake at night. You arrange for Tyler's mother to meet you and Tyler at the youth centre after school one day. Tyler and his mother provide consent to exchange information with Tyler's GP, his school, the local hospital and the community health centre.

NEGOTIATING BETWEEN SERVICE SYSTEMS

You know of a paediatrician at the local hospital who sees adolescents, but a GP's referral is needed in order to see him. You contact the local hospital and find out that the paediatrician has recently commenced a limited multidisciplinary weight management clinic for overweight children and adolescents up to the age of 16.

You help Tyler and his mother get an appointment with his GP for a health review and to consider referral to the adolescent Weight Management Clinic. You discuss the financial strain on the family with the GP and he agrees to bulk bill this appointment.

You contact the school welfare coordinator to explain your concerns that Tyler is being constantly "teased" about his weight.

PROGRESS OVER TIME

The GP assesses that Tyler has mild asthma and eczema and provides him and his mother with information about treatment. Tyler takes the prescribed medications and finds that his symptoms improve dramatically. The GP refers Tyler to the weight clinic because this also offers group activities and dietician support.

Tyler's mother finds it difficult to attend the family appointments with Tyler because of childcare issues, which makes it difficult for her to provide the necessary family support for healthy eating. You help Tyler's mother identify potential childcare options so that she can attend Tyler's appointments with him. On one occasion, you accompany Tyler, his mother and sisters to the clinic and stay with the younger children while his mother goes in with Tyler to see the dietician.

At the youth centre, you initiate a new group physical activity program. Tyler comes along and participates in a weekly basketball tournament. He enjoys this much more than school sport because he does not feel as self-conscious. Tyler introduces another boy from school to the youth centre and they both continue to attend regularly. Tyler reports still being teased occasionally at school but says he is not as bothered by it.

CASE STUDY: CASE MANAGEMENT FOR ELISE

Elise is a 14 year old Anglo-Australian girl who was placed in the care of the Minister three weeks ago. She is staying in a supported accommodation service run by a Non Government Organisation (NGO). The NGO has allocated her a carer within the accommodation service as well as a Case Manager. Elise also has a Community Services case worker.

She is in Year 8 and has changed schools since moving into supported accommodation. In her previous high school she had a history of truancy.

STEP 1: ASSESSMENT

Basic needs

Elise did not have regular access to food at her family home. She was often left unsupervised for long periods while her parents worked. Elise has stolen food from other school bags because she was hungry.

Educational/occupational needs

Elise missed most of the school year at her previous school. Her new school is the fourth high school she has enrolled in.

Health needs

Elise mentioned that she has trouble concentrating at school and some reading difficulties. She experiences sudden mood swings that she finds hard to control. She appears thin and pale. Elise finds alcohol use helps with the mood swings and has reported some instances where she cannot remember what has happened due to blackouts. Elise has disclosed that she has had unprotected sex.

Social and cultural considerations

Elise has struggled to maintain friendships with her peers as she has moved schools several times. There is concern that Elise may be spending time with an older group of young people who buy alcohol for her.

STEP 2: PLANNING

There is an opportunity to plan for and facilitate a comprehensive assessment of Elise's health and developmental needs.

Needs	Potential services that can respond
Cognitive/psycho-metric/developmental assessment	Paediatric/ adolescent specialist services, psychological services, education sector
Physical assess-ment: sexual and reproductive health, physical issues relating to substance use, physical growth and development	General practice, youth health, paediatric/adolescent specialist services, sexual health, drug and alcohol services
Mental health assess-ment: particularly to identify a possible mood disorder	General practice, youth health, headspace, mental health

In planning Elise's management, her Case Manager:

- Gathers as much information as possible from any previous assessments
- Discusses Elise's needs and possible service responses with Elise and her carer
- Identifies the most appropriate services (considering one-stop-shop options, cost, location, waiting time)
- Considers the 'real world' – what is practical and feasible for Elise and what Elise wants to do
- Prioritises the assessments if necessary

Elise does not want to attend multiple appointments. She does not express any health concerns of her own, except she states she does not want to become pregnant.

Many of Elise's health needs can be assessed at the local youth health service. Past psychometric and developmental assessment reports can also be obtained. The school counsellor can do an updated psychometric assessment at the school in which Elise is currently enrolled (although she has not been attending).

FACILITATION

Elise's Case Manager sets up an appointment for Elise at the youth health service where she can see a nurse and a doctor. The Case Manager makes sure Elise has her Medicare card and organises transport for the carer to take Elise to and from the appointment. She has also sent Elise's previous psychometric and health assessments to the youth health service in advance. At the same time, she provides the name and contact details of the school counsellor to the youth health service.

MANAGEMENT

Following Elise's appointment at the youth health centre, a number of further assessments are recommended. Elise needs a dental review and possible orthodontic work; a vision assessment with an optometrist; and a referral to a Family Planning Clinic for the contraceptive implant. She has had some blood tests done and needs follow up with the doctor at the youth health service.

An internal referral to one of the youth health counsellors is offered and Elise reluctantly agrees. Elise is offered ongoing counselling in the youth health service but is ambivalent about attending.

With Elise's knowledge and consent, the Case Manager works with the youth health nurse to plan and facilitate these assessments and treatments. The Case Manager also liaises with Community Services to seek funding for orthodontic assessment and for glasses (i.e. services not covered by Medicare).

After Elise has attended these appointments, a case management meeting is arranged, organised by the Case Manager. The meeting is attended by the Case Manager, the youth health nurse and doctor, the youth health counsellor, the school counsellor, the Community Services caseworker and Elise.

MONITORING

Elise continues to engage in some health risk behaviours (including binge drinking); however some of her health needs have been addressed, including immunisation updates, obtaining contraception and sexual health screening.

The Case Manager is not privy to all the details of Elise's health risks or to results of all tests, but has an understanding of Elise's health needs more broadly. The Case Manager identifies a GP who can provide ongoing care for Elise and discusses this with the youth health doctor and nurse. The Case Manager ensures a smooth transition from the medical team at the youth health service to the GP.

ADVOCACY

Elise misses her appointment at the dental clinic as she has truanted from school and could not be contacted in time. Elise is told by the dental clinic that she will have to wait six months for another appointment. Her Case Manager is able to effectively advocate for special consideration and she is offered another appointment in one month's time.

REVIEW

Four months after entering out of home care, Elise meets with her carer and the Case Manager to formally review her health and other needs. Many of Elise's physical health needs have been addressed, but she continues to binge drink and there is some concern that she engages in unprotected sex. Her school attendance is also problematic. The Case Manager obtains recommendations from the school counsellor, the youth health counsellor and the GP to assist in preparing for further management.

CASE STUDY: WORKING COLLABORATIVELY TO SUPPORT JOSH

Josh is 15 years old and lives in the western suburbs of Sydney with his mum and dad, 3 brothers and a newborn sister. Josh identifies as an Aboriginal person and has a large extended family. Josh had a kidney transplant in 2006 and has an acquired brain injury.

Josh's home is busy. Both Josh's parents work and the new baby is taking up a lot of his parents' time and energy. Josh is close to his parents and says he misses having time with his parents. There is not a lot of spare money for entertainment or outings.

Josh also has a large extended family of aunties, uncles and cousins. He gets a lot of support and encouragement from his older cousins and an uncle and auntie who live nearby.

Josh admits to having a problem with his temper. He has a behaviour management program to help him better manage his emotional responses.

Josh has been referred to you for help with planning his transition to adult health services. You arrange to see Josh and his family at home.

PLANNING: IDENTIFY JOSH'S NEEDS

Basic needs

Josh has good verbal communication skills but has difficulties with reading, writing and remembering information. He needs practical help with transport, remembering to take his medication, money management, completing school work, and (at times) with behaviour management. Josh has received some assistance but he will need ongoing support.

Josh says he's not really sure why it's important to talk about transition: he feels he's got plenty of time until he's 18. You explain that transition planning starts early so that the transition goes smoothly.

Education/occupational needs

Josh plans to stay at school and complete his HSC. He is given extra time to do his school work and exams, and he has help from someone who takes notes during class. Josh does well in creative subjects such as art but struggles with maths and English. He understands his limitations with schooling, as do his mum and dad. Josh loves doing design and painting work, screen printing and using computers. He wants to undertake an apprenticeship after completing his HSC.

Josh has a part-time job in a café. He enjoys the financial independence this gives him and has helped build his confidence in being part of the workforce and providing customer service.

You provide Josh with information on apprenticeships that are being offered to Aboriginal people.

Health needs

Josh needs to take regular medication to stay well. His mum and dad are supportive and remind him to take his medication. You talk with Josh about ways to help him manage his medication such as setting reminders on his phone and learning how to keep a diary.

Josh doesn't have a GP but would like to find one, as he knows it will be important when he turns 18 and becomes more responsible for his health. You and Josh agree that finding a GP is a high priority. You talk to Josh about finding a new GP and talk with him about helpful questions to ask so he can find the right person for him.

When Josh finds a GP, they can complete a GP Management Plan to help support Josh through his transition. You offer to call some GPs for Josh to help him in his search and give him a list of others he can contact.

Josh sees a psychiatrist regularly for help with managing his behaviour.

Social and cultural considerations

Josh knows that his kidney transplant makes it even more important that he lead a healthy lifestyle. He knows his peers are starting to drink alcohol and that he won't be able to do that. He talks about how this could isolate him from his friends, but he accepts he needs to put his health first. You give Josh some helpful websites where he can access information about staying healthy.

Josh's family can't afford many social outings as a family. Josh feels frustrated and would like to be doing more with his family. You know that the local community centre has regular family days, and you give Josh some information about these and other free local activities.

KNOWING WHEN TO REFER

Josh's ability to understand the implications of sexual relationships is limited. You refer Josh to NSW Family Planning so that he can talk to one of the professionals about sex and relationships. Josh found this appointment helpful and was happy the services were free and confidential. He said he learnt a great deal about contraception and really liked getting free condoms.

EXERCISING JUDGMENT

Josh understands his own limitations in cognition and how his medical condition will affect his social life. You will need to consider these needs when planning and coordinating Josh's care during transition. Monitoring Josh's health during his transition will be an important part of the transition plan. Encouraging Josh to develop a good relationship with his GP, to see his GP when he is feeling unwell, and to talk openly about his life is important because the GP will become an important health professional for Josh when he turns 18.

SHARING INFORMATION

Josh has signed a consent form to be enrolled in the transition service and you explain how information sharing works. Josh says he's happy for you to share his information with other health professionals and will let you know if there is something he doesn't want shared.

NEGOTIATING BETWEEN SERVICE SYSTEMS

Once Josh has a GP, the GP will assume responsibility for coordinating Josh's care. Liaising with Josh's GP is integral to a successful transition and to ensure Josh's health outcomes are optimised. You start collating Josh's medical information, discharge summaries and outpatient clinic letters to assist the GP in looking after Josh.

You and Josh visit the adult hospital so he can see what it is like and meet some of the professionals who work there. Josh comments on the visual differences between the hospitals, and asks if his parents can attend appointments with him. You explain that in adult health services he will be encouraged to see his health professionals on his own so he can talk freely with them. Josh likes the idea of having his own health professionals, but seems a little concerned. You reassure him that if he wants his parents or a family member or friend there for any reason, he can always talk to the health professional about it.

PROGRESS OVER TIME

Josh calls you two weeks later to say he has found a GP he likes. It wasn't easy, but Josh said he was determined to find the right person for him so he contacted GP surgeries in his area and met with them to see how much they knew about his condition; if they were happy to talk to him about sex and relationships; and if he could see them when he wasn't feeling good within himself. He made sure the GP was happy to meet these needs.

With Josh's permission, you contact the GP to discuss preparation of a GP Management Plan. Josh asks you to organise a meeting with all his health professionals so everyone is aware of what they are doing during his transition. Because Josh cannot get around easily, you organise a teleconference, giving Josh the chance to talk to all his professionals at once. Josh also gets to hear who is responsible for what with his care.

Josh tells you that he and his family went to a picnic in his local community and it was great for his family to spend some time together. And he said it was free!

FINDING OUT MORE...

For more information about transition, see chapter 3.11 Chronic conditions and disability.

CHAPTER SUMMARY – WHAT TO REMEMBER

Collaborative care produces good health outcomes. For young people, a positive experience of being involved in making decisions about their health and wellbeing helps develop their confidence and their ability to engage in future help-seeking behaviours.

Collaborative care may, in fact, be essential when trying to address complex or psycho-social conditions which often emerge in adolescence.

In some cases, where the needs of the young person are particularly complex, a more proactive approach to aligning the health services and resources around the young person may be required through case management.

REFLECTION QUESTIONS

What does collaboration mean within your service?

Who do you collaborate with? Who should you be collaborating with and why?

Develop a pathways map to demonstrate the connections into, and beyond your service, from a young person's perspective.

What are you doing well? How are you effectively building relationships?

Are you falling into any pitfalls in collaboration?

What resources do you need to strengthen your collaboration and who is best placed to help address these needs?

Does anyone in your organisation perform a case management role either formally or informally?

REFERENCES

NSW CAAH. (2005). *Better practice in youth health: final report on research study Access to health care among young people in New South Wales Phase 2*. NSW CAAH: Westmead, NSW.

NSW CAAH. (2012). *Youth Health Better Practice Framework*. 2nd ed. NSW CAAH: Westmead, NSW.