Larundel Hospital

Community Department June 1983.

Larundel's Community Department, formerly known as the Social Work Department, has a staff of 7 social workers (including 2 half-time) and 4 Community Nurses, 1 Welfare Officer, 2 Case Aides, 2 Receptionist-typists, and 3 Interpreters. The department head is a Social Worker and the deputy head is a Community Nurse. This staff is divided into 5 teams, 4 of which comprise a Social Worker and a Community Nurse; each has an allotted region in Larundel's catchment area. This has been done to give a manageable area for home visiting and to enable a thorough knowledge of local resources.

The three short-term Larundel wards were regionalised in 1977 to facilitate the department's move into the community, and recently this has been extended through all wards, from the acute admission ward outwards (see attached diagram.) This means that the same key personnel (Psychiatrist, Medical Officer and community team) are concerned in each patient's management from admission to discharge.

Method of Operation

Each community team at Larundel spends approximately 3/5ths of its time working in its allotted region, returning to the hospital on specific days to attend patient reviews and contact new patients and those ready for discharge. Each team builds up a detailed knowledge of community resources available in its area and liases closely with personnel in local helping agencies, some of which provide a basis in the form of office space and use of 'phone messages for the team.' Most clients are seen in their homes but in some cases an office at the "base" agency is used. Hospital cars are provided for the teams though private cars have to be used in some cases.

Most teams carry paging devices to enable them to be contacted when emergency referrals come into the Community Department. Those without them ring in at regular intervals for messages. In this way a 9 - 5 crisis intervention service is maintained.

In addition to priority follow-up of discharged hospital patients, referrals (nearing 50%) are also made to the teams from community agencies, members of the public, local G.P.'s and the police. The teams are listed in local community resource handbooks and are known to local Citizens' Advice Bureaux.

Advantages of the Community Service provided

(1) More intensive and specialised use of a relatively small number of personnel whose services were formerly spread too thinly in the hospital.

(2) More comprehensive assessment of clients through

a) Dual team of Social Worker and Community Nurse.
b) Seeing patients in home environment.

(3) Benefits of incorporating clients in existing community groups and not isolating them in groups designed exclusively for ex-psychiatric patients, (i.e. in Mental Health Clinics.)

(4) Cost-effective coverage of large portion of catchment area where not mental health clinic exists - including provision of medication where necessary. (Medical back-up from hospital).

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(5) On-going supervision of ex-patients with psychiatrists back-up for consultation or assessment as required is more efficient use of psychiatrist's time.

(6) Continuity and consistency of care from admission to discharge follow-up.

(7) Analysis of figures shows a reduction in re-admission rate of chronic patients since service introduced.

The case-aides in the Department handle patient's pensions and sickness benefits. They are also responsible for placement of patients in Special Accommodation Houses and for follow-up. A Welfare Officer provides help to patients for independent accommodation and for community half-way houses.

An interpreter service which covers patients from Larundel and neighbouring hospitals and clinics is also available in the languages of Greek Italian, and Serbian/Croation. (Other languages can be provided for by Central Health Interpreter Service).

COMMUNITY DEPARTMENT

All referrals and messages for any member of the Community Department are to be left with the Receptionist who will then pass the referral onto the appropriate person.

Phone No. extension 239, 380 and 354

SOUTHERN REGION

Team - Pauline Schofield and Marie Winfield - Case Aide, Kristine Birchall

Hughesdale	Clarinda	Parkdale	Cheltenham
Oakleigh	Coatesville	[illegible]	Brighton
Huntingdale	E. Bentleigh	Highett	McKinnon
Clayton	Moorabbin	Mordialloc	
	N. Cheltenham	Pennydale	

Team - Megan Erm and Margaret Mayer - Cities of Caulfield, Malvern, St. Kilda

St. Kilda	Armadale	Glen Iris	Chadstone
Elwood	Caulfield	Glenhuntly	Gardenvale
Elsternwick	S. Caulfield	Carnegie	Ormond
E. Malvern	Murrumbeena	Balaclava	
Malvern		Ripponlea	

OUTER EASTERN REGION

Team - Helen Hodgson and Peter Borthwick - Case Aide, Agnes Spinks

KNOX	HEALESVILLE	UPPER YARRA
Bayswater	Marysville	Woori Yallock
Boronia	Steeles Creek	Warburton
Ferntree Gully	Yarra Glen	Launching Place
Knoxfield		Yarra Junction
Rowville		Wesburn
The Basin		Millgrove
Wantirna		
Wantirna S.		
Scoresby		

Team - Fiona Moore (Part-time Monday, Tuesday and Wednesday)

RINGWOOD	WAVERLEY	
Heathmont	Ashwood	Mulgrave
Heatherdale	Glen Waverley	Notting Hill
Ringwood E.	Holmesglen	Springvale N.
Ringwood N.	Mt. Waverley	Syndal
	Jordanville	Wheeler's Hill

Team - Maureen Davidson (Part-time Monday, Tuesday and Wednesday)

LILYDALE	CROYDON
Mooroolbark	Croydon N.
Montrose	Croydon S.
Wandin	Bayswater N.
Seville	Warranwood
Kalorama	Monbulk
Mt. Evelyn	Kilsyth
Coldstream	
Wonga Park	

Psycho-geriatric Team - Jan Workman, Community Nurse
Diane Molloy, Social Worker

All in-patient emergencies - Jan Workman, Community Nurse,
Diane Molloy, Social Worker.