**Compeer Friendship Program Referral Guidelines**

**Who is the Compeer Friendship Program suitable for?**

Compeer is a friendship program that matches trained volunteers in one-to-one friendships with people who have a diagnosed mental illness. The program is suitable for people in the community aged 18 years or older who are socially isolated. Compeer is an adjunct to services offered by mental health and allied health professionals. The program aims to provide a world that does not revolve around illness but around common interests and connection to communities.

Eligible consumers who live in the ACT are encouraged to apply through their health care professional.

The health professional can confirm that the consumer is eligible by consulting the checklist on page 2 and following up with Compeer if necessary.

**Who can make an application to Compeer?**

* A health professional and the consumer (applicant) can make an application
* The applicant must be receiving ongoing care from the health professional whilst the applicant is participating in the program

(Health professionals include general practitioners, psychiatrists, clinical psychologists, psychologists, mental health case managers, mental health support workers, social workers, occupational therapists and mental health nurses)

**Application Checklist**

* Health professional completes essential criteria checklist. If applicant is eligible, continue to suitability assessment
* Health professional completes Part 1 to 8 of the application form
* Applicant completes Part 9 and 10 of the application form (with assistance if required)
* Applicant and health professional sign application form
* Applicant and a witness read and sign consent form
* Health professional attaches supporting mental health history information if appropriate

Please return the completed application to Compeer by post, fax or email. **Compeer Program**

**PO Box 51,
Deakin West ACT 2600****compeer.cg@vinnies.org.au**

If you are unsure about any aspect of the application process, please contact the Compeer Officer by phone 0427 930 460 or email compeer@svdp-cg.org.au

For office use only. Date of receipt:

**Compeer Friendship Program Referral Form**

**Person being referred:**

**COMPEER ELIGIBILITY CHECKLIST - HEALTH PROFESSIONAL TO COMPLETE**

Please only apply if the consumer is eligible. Should you have any questions regarding eligibility, contact the Compeer officer: **Phone: 0427 930 460 Email:** **compeer.cg@vinnies.org.au**

|  |  |
| --- | --- |
| **Essential Criteria** | **circle yes or no** |
| 1 | The applicant is 18 years or over | **Yes** | **No** |
| 2 | The applicant’s primary diagnosis is an identified mental health disorder | **Yes** | **No** |
| 3 | The applicant has stable housing | **Yes** | **No** |
| 4 | The applicant is not acutely unwell or experiencing acute suicidality | **Yes** | **No** |
| 5 | The applicant is not displaying physically or verbally aggressive behaviour | **Yes** | **No** |
| 6 | The applicant has identified as being socially isolated and is willing to participate in the Compeer Program | **Yes** | **No** |
| 7 | The applicant can arrange travel to meet the volunteer in a public place | **Yes** | **No** |
| 8 | The applicant will be seeing a health professional during the time s/he is participating in the Compeer Friendship Program | **Yes** | **No** |

**If all of the above questions have been circled yes, please proceed**

|  |  |
| --- | --- |
| **Suitability Assessment** | **circle yes or no** |
| 9 | Does the client have a personality disorder/suspected personality disorder? | **Yes** | **No** |
| 10 | Does the applicant have an intellectual disability? | **Yes** | **No** |
| 11 | Is the applicant dependent on drugs and/or alcohol? | **Yes** | **No** |
| 12 | Does the client have an acquired brain injury or neurological condition? | **Yes** | **No** |

Please note that questions 9 to 12 identify populations for which the Compeer program is generally unsuitable. However each application will assessed on a case-by-case basis.

There may be additional factors identified during the application process which could lead to Compeer being unable to accept an application.

Please contact the Compeer officer to discuss any questions you may have. Telephone: 6234 7309

**Part I**

**To be completed by the Health Professional supporting the Compeer friendship. Please print clearly**

**Referring Health Professional Contact Details:**

|  |  |
| --- | --- |
| Name |  |
| Position/Title |  |
| Agency/Practice/Team |  |
| Address |  |
| Phone |  |
| Mobile |  |
| Fax |  |
| Best time to be contacted |  |

**Part 2**

**Current Involvement:**

|  |  |
| --- | --- |
| How long have you worked with applicant? |  |
| How often do you see applicant? |  |
| How long is your treatment plan? |  |
| Are you the applicant’s primary health professional?  |  |
| If not, who is the primary health professional? Please supply name and contact details |  |
| Is the primary health professional aware of this application? |  |

IF THE APPLICANT EXITS YOUR CARE, PLEASE ADVISE COMPEER OF THE CHANGE IN HEALTH PROFESSIONAL

**Part 3**

**Social Functioning**

|  |  |
| --- | --- |
| Please describe the applicant’s personality and strengths |  |
| Please describe the applicants interpersonal and relationship skills |  |
| Is the applicant able to look after her/himself on a daily basis? (e.g. self-care) |  |
| Are there any social goals that the applicant is currently working towards? |  |

**Part 4**

**Mental Health Diagnosis**

(Please provide as much detail as possible and attach additional documentation if appropriate)

|  |  |
| --- | --- |
| Diagnosis |  |
| SymptomsCurrent: |  |
| SymptomsWhen client is becoming unwell: |  |
| SymptomsWhen client is unwell: |  |

**Part 5**

**Mental Health History**

|  |  |
| --- | --- |
| When was the applicant diagnosed? |  |
| Circumstances |  |
| Hospital admissions |  |
| Any fluctuations? |  |

**Part 6**

**Current Management**

|  |  |
| --- | --- |
| Does the applicant take medication to manage her/his mental illness? If yes, please specify any relevant side effects and compliance issues |  |
| Is the applicant receiving any care and support (psychologist, counsellor, community programs, NDIS etc.)?   |  |
| Is the applicant currently on a community treatment order? |  |

**Part 7**

**Risk Assessment**

|  |  |
| --- | --- |
| What is the applicant’s current suicide risk (over the last 6 months)?  | Pease circle Nil Low Medium High  |
| Is the applicant currently experiencing suicidal ideation?  |  |
| Does the applicant have a history of suicidal behaviour?  |  |
| Does the applicant engage in self-harm?  |  |
| Please provide relevant detail regarding suicidality and self-harm (including history, management and protective factors) |  |
| What is the applicant’s current risk to others (over last 6 months)?  | Please circle Nil Low Medium High  |
| Is the applicant currently experiencing thoughts of harming others? |  |
| Have there ever been incidents of verbal or physical aggression?  |  |
| Does the applicant have a criminal record or has s/he been the subject of an Apprehended Violence Order? |  |
| Is the applicant experiencing violent or threatening behaviour from others? |  |
| If yes, is this likely to impact on the volunteer and/or outings? |  |
| Does the applicant have a history of alcohol or drug use? |  |
| If yes, please provide relevant details regarding drug and/or alcohol use (including substance, frequency,amount, history)  |  |
|  |  |
| If yes, how might this impact on her/his Compeer friendship? (please specify management, treatment and protective factors) |  |
| Does the applicant have other addictive/compulsive behaviours that may affect social functioning with a volunteer (e.g. gambling, shopping, OCD behaviours) |  |

**Part 8**

**Intellectual and Physical Disabilities and Medical Conditions**

|  |  |
| --- | --- |
| Does the applicant have an intellectual disability?  |  |
| If yes, please comment on the severity of the intellectual disability |  |
| How might the intellectual disability impact specifically on the Compeer friendship/choice of activities? |  |
| Does the applicant have any physical limitations? |  |
| How might the physical disability impact specifically on the Compeer friendship?  |  |
| Does the applicant have any medical conditions? |  |
| If yes, how is her/his condition/s managed? |  |
| How might her/his medical condition/s impact specifically on the Compeer friendship/choice of activities? |  |

**For The Supporting Health Professional**

I agree that the information provided is current and accurate to the best of my knowledge.

If the information changes, I agree to contact Compeer and update the information.

I agree to support the applicant in the Compeer Program for the duration of their participation.

I understand and agree to:

Be available to Compeer staff regarding issues concerning the applicant

Be available to attend a meeting with the Compeer Officer and the potential volunteer

If appropriate, I will attend a meeting with the Compeer Officer, the potential volunteer and the applicant

I will contact Compeer if the applicant is no longer under my care or if the applicant has changes in wellness, circumstances or contact details

Name of Health Professional \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 9**

**Applicant’s Details**

To be filled out by the applicant (with the health professional’s assistance if required)

|  |  |
| --- | --- |
| Applicant’s name |  |
| Address |  |
| Home telephone |  |
| Mobile number |  |
| Email |  |
| Date of birth |  |
|  |  |
| Gender |  |
|  |  |
| Country of birth |  |
| What languages do you speak? |  |
| Are you in a relationship at the moment? |  |
| Do you have any children? |  |
| Do you smoke? |  |
| Who can you rely on for support? (eg family, friends, work colleagues) |  |
| Living situation? (eg. alone/group home/with family) |  |

|  |  |
| --- | --- |
| Emergency contact: name |  |
| Emergency contact: phone number |  |
| Relationship to the emergency contact |  |

**Part 10**

**Matching you with a volunteer**

Compeer is a friendship program that matches trained volunteers in one-to-one friendships with people who are living with a diagnosed mental illness. We believe that friendship helps to change lives and challenge social isolation.

You and your volunteer will decide together what you both want to do when you meet. Activities should be low or no cost so that you and the volunteer can afford to participate and pay your own way.

|  |  |
| --- | --- |
| What do you usually do every day? (including work, study, activities, visits) |  |
| What would you like the volunteer to know about you? (What do you like to do? What don’t you like?) |  |
| How would you describe your personality? |  |
| What sort of activities would you like to do with the volunteer? |  |
| What days and times are best for you to meet your volunteer? |  |
| Can you be flexible with these days/time? |  |

**Compeer matches applicants with volunteers based on age, similar interests and gender**

|  |  |
| --- | --- |
| What other factors do you want us to take into consideration when we are making a match? (e.g. language, religion, cultural background, sexual orientation) |  |

**We will try our hardest to match your preferences but we cannot guarantee that we can meet all your requests**

**Meetings**

|  |  |
| --- | --- |
| Compeer meetings and outings occur in public places and you and your volunteer travel independently. How would you travel to meet your volunteer?  | Please circle: public transport drive yourself walk other  |
| Do you have any physical difficulties that might make getting around a challenge? Please describe |  |
| Are you comfortable travelling outside of your local area? If yes, what areas are you able to travel to? |  |

I agree to participate in the Compeer Program.

I agree that the information provided is current and accurate to the best of my knowledge. If the information changes, I agree to contact Compeer and update the information.

I understand that I must have a supporting health professional for the duration of my participation in the Compeer Program.

I will inform Compeer if I change health professional or no longer have a health professional supporting me.

If/when I am matched, I agree to meet the volunteer independently in a public place on a weekly basis and pay my own way on outings.

Name of Applicant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please continue to next page*

**Compeer Applicant Consent Form**

St Vincent de Paul Canberra/Goulburn (Vinnies) works collaboratively with government, community and private organisations to achieve best outcomes for the people we support. Vinnies is under licence agreement to deliver the Compeer Friendship Program, as part of the Vinnies Special Works Program. This consent form allows Vinnies to use and disclose the personal information of the participant so that the Compeer Program can provide the best possible service.

**Commonwealth Privacy Act 1988 (as amended)**

The primary purpose of the collection of your personal information is for Compeer to match people applying to the Compeer Program with a suitable volunteer and to support the match. Compeer collects the following information:

* Name
* Date of birth
* Current address and contact phone number
* Country of birth
* Emergency contact
* Medical history
* Social history

The information provided will be disclosed to:

* Compeer staff and the Compeer volunteer you are to be matched with
* Other health professionals, as required
* Others as required by law
* To the person you have designated as the “person responsible” for giving and accessing your information

Your personal information is kept in a secured storage and will not be disclosed to third parties without your consent unless it is an emergency and/or required by law.

The purpose of this form is to also advise you that you may obtain access to the information we hold on you within a specified time frame by contacting the Compeer Officer at the address below.

It is important that we outline what the main consequences may be if you do not provide all, or part of, the information requested:

* Compeer may be unable to provide appropriate services and care
* Vinnies may be unable to meet individual requirements of the mental health consumer (applicant)

I have read and understood the above and consent to the intended uses and disclosures of the personal information obtained by the Compeer Program.

Name of Applicant (or person responsible):

Signature Date

Name of Witness:

Signature Date

This consent is valid for a period of 12 months, or until I no longer receive support from Vinnies.
Consent can be revoked at any time by written request.

Compeer Officer

St Vincent de Paul Society - Canberra/Goulburn

Phone: 02 6234 7309

Mobile: 0427 930 460

Fax: 02 6281 4743 PLEASE ATTACHED FRONT PAGE WITH: **CONFIDENTIAL**

Email: compeer.cg@vinnies.org.au

**Please make a copy of the Compeer** **Applicant Consent Form for the applicant to keep.**