



Integrated Mental Health Service Project

Final Report

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The *Integrated Mental Health Service Project (IMHSP)* is a project of Sector Connect Inc and is funded by South Western Sydney Primary Health Network (SWSPHN)

▶ Executive Summary

On behalf of the South Western Sydney PHN, Sector Connect embarked on a process of consultation and co-design, to develop a design for a new, trial integrated subspecialty clinic providing coordinated, wrap around care for people living with severe and persistent mental illness. The project consulted with 205 stakeholders, followed by a co-design workshop with 14 key participants, focused on further refining the service model and how it may be managed. The outcome is a single design for the service, with recommendations and important considerations.

The consultation and co-design process culminated in a broad agreement that the service will be based around a general practice, with coordination between General Practitioners and related personnel, mental health services, social support services and other allied health services. It was suggested that service coordination and communication occur through a coordinator of care role, case conferencing, single referral system and shared information systems. The preferred model of governance was a consortium managed by a lead agency with agreements between all participating services. A number of barriers and solutions were also presented during the co-design workshop, which would prove vital to consider in order to support the success of the venture.

The *Integrated Mental Health Service Project* engaged the health, non-government and government sectors in designing innovative solutions to address issues of service fragmentation and poor health outcomes experienced by people living with severe and persistent mental illness. The model presented can be adapted to various contexts, creating exciting opportunities for the model to be replicated in other areas. It has also encouraged conversations on integrated and coordinated care, and ways of supporting people living with severe and persistent mental illness. In respect to this, the *Integrated Mental Health Service Project* paves the way for improvements in service delivery and coordination for the treatment and support of people living with mental illness.

▶ Acknowledgements

Sector Connect would like to first and foremost acknowledge the South Western Sydney PHN for their support and sponsorship of the *Integrated Mental Health Service Project*.

Sector Connect would also like to thank the *Integrated Mental Health Service Project* Advisory Committee, consultation and co-design participants, and Community Owned Primary Health Enterprises (COPHE) for their valuable and ongoing support and involvement in the *Integrated Mental Health Service Project*.

Finally, Sector Connect would like to acknowledge the support and encouragement of all Sector Connect staff, members and the Management Committee.

► Background

► The Issue

The National Mental Health Plan approximates that 3% of the Australian adult population live with severe mental disorders (Commonwealth of Australia 2009). This is often combined with comorbid physical disorders such as cardiovascular disease, diabetes and cancer (Australian Institute of Health and Welfare 2012). Although the population of people living with severe mental illness is low, the burden on a person and on the system is significant. The *2010 Survey of High Impact Psychosis* shows high rates of chronic disease for people living with serious mental health conditions (Morgan, V. A. et. al. 2011). These include higher than average rates of diabetes, asthma, arthritis and cardio metabolic risk factors. Poor physical health in these populations can contribute to the lower than average life expectancy of up to 20 years less than the average person (The Mental Health Commission of NSW 2014).

Severe mental illness can also have a two-way relationship with social inequalities; with social inequalities resulting in increased risk of many mental health disorders (World Health Organisation and Calouste Gulbenkian Foundation 2014). Social conditions impacting mental health can include low income, inadequate housing, lack of education, unemployment, insecure employment, high demand or low control work, child neglect/abuse, gendered violence and social isolation (Fisher M. and Baum F. 2010).

Locally, the *2014 Population Health Needs Assessment* surveyed and consulted with residents of the South Western Sydney Local Health District (Medicare Local and South Western Sydney Local Health District 2014). Respondents expressed a lack of locally based services required to meet this high demand. Existing services were perceived to be complex and fragmented, therefore, difficult to navigate and access. Respondents felt there was poor communication between providers, and were concerned about the comprehensiveness of their care. Furthermore, 13.6% of respondents experience high levels of psychological distress, significantly higher than the NSW average of 11.2% (NSW Department of Health 2010). General Practitioners who have been consulted also express the need for more support in treating patients living with severe and persistent mental illness.

The South Western Sydney Local Health District further added to these concerns in the *South Western Sydney Local Health District Strategic Priorities in Health Care to 2021*, approximating an increase of 88.02% in the number of mental health beds required by 2021. More generally, the South Western Sydney Local Health District is reported to currently be resourced significantly below the NSW average. A solution highlighted in the report is the need to, “engage with private and non-for-profit health providers collaboratively to meet high demand” (South Western Sydney Local Health District 2013).

► Context

The *Integrated Mental Health Service Project* is rooted in previous consultations and program delivery by Sector Connect, COPHE (Community Owned Primary Health Enterprises) and South Western Sydney Partners in Recovery. Findings from these projects resulted in the development of various models of integrated care. One such model was that of, “an integrated mental health service in the region” developed by, “engaging partners (financial/operational and clinical) and locating a site” (*Mental Health Service Integration Project 2015-2016 Final Report 2016 pp. 24*). The South Western Sydney PHN, in response to this report, recognised that this particular model supports primary health services in providing holistic treatment of people living with severe and persistent mental illness, by integrating key health and support services.

▶ Project Aim

The *Integrated Mental Health Service Project* aimed to co-design a brief for a trial integrated sub-specialty clinic within a General Practice that delivers wrap around clinical care, care coordination and appropriate referrals for people living with severe mental illness. This was achieved through consultation and co-design with key stakeholders (see **Project Methodology**). The proposed service intends to address issues of an existing, fragmented system, the high demand for primary and mental health services and the impact of physical health and social outcomes on people living with severe mental illness.

▶ Project Outcomes

At the conclusion of the *Integrated Mental Health Service Project*, the following outcomes had been achieved:

- Development and delivery of a completed co-design process that involved key stakeholders, including primary and mental health care providers, South Western Sydney Local Health District, non-government services, private practice, consumers/Carers and other local players, and was evaluated to be rigorous and well-accepted.
- Submission of a final report outlining a preferred design for the proposed service, with a summary of participant feedback and recommendations on suggested contract conditions and implementation principles.

▶ Project Methodology

The consultation and co-design process invited a wide range of people to participate in the design of an integrated primary and mental health clinic. Stakeholders were identified by Sector Connect, South Western Sydney PHN and the project's Advisory Committee. Consultation participants were recruited through social media, online platforms, broad mail outs, targeted newsletters and, existing networks and contacts. Consultation participants were then invited to participate in a co-design workshop. All contributors were provided, in advance, a detailed *information kit* and a *short summary* describing the project and the proposed model, to prepare them for participation in the consultations.

The consultations engaged a total of 205 individuals representing a range of services and sectors. Participants were engaged through 9 interagency and networking meetings, 16 one-on-one interviews, 3 targeted surveys and 4 group workshops. The co-design workshop brought together 14 of these individuals in a series of evaluation, brainstorming and prioritisation sessions.

Participants were asked to provide feedback on the initial model, with particular focus on the following areas:

- What services should be included in the model?
- What are the strengths and weaknesses of the model?
- How should service coordination/integration occur?
- How should the clinic be governed?
- How might the model be sustainable?
- How might the model be scalable?
- Where a trial clinic should be established?



► Rationale and Attempts at Integrated Care

Integrated models of care have been attempted, with various degrees of success, in Australia and across the world. The Mental Health Commission of NSW *Living Well Report*, a strategic plan for mental health in NSW (2014-2024) recommends an integrated approach to care, stating that, “integrated care is seen not only as important to improving the health of consumers – and helping them to recover from both physical and mental health problems – but as a way of reducing inefficiency and waste. Integration saves money” (The Mental Health Commission of NSW 2014). The report shares a number of common factors that contribute to the provision of effective care coordination for people living with mental health needs, including:

- Information-sharing systems
- Shared protocols
- Joint funding and commissioning
- Co-located services
- Multidisciplinary teams
- Liaison services
- Care navigators
- Research
- Reduction of stigma

Furthermore, in 2014 the NSW Ministry of Health launched its *Integrated Care Strategy (2014-2017)*. The NSW Ministry of Health states that, “Integrated care involves the provision of seamless, effective and efficient care that responds to all of a person’s health needs, across physical and mental health, in partnership with the individual, their Carers and family. It means developing a system of care and support that is based around the needs of the individual, provides the right care in the right place and the right time, and makes sure dollars go to the most effective way of delivering health care for the people of NSW.” Having seen the vast benefits of adopting integrated models of care, the NSW Government committed \$180 million over six years to implement innovative, locally led models of integrated care across the State, to transform the NSW healthcare system.

Therefore, there is clear support and evidence for integrated models of care. Examples of integration in Australia and overseas include:

- *LikeMind*, an adult service for people living with mental health issues, providing access to a range of health and community services in the one location. Clients work with a healthcare professional to develop a Coordinated Care Plan, following which the client is connected to services in mental health care, alcohol and other drugs, employment and training support, housing assistance and access to General Practitioners, Psychologists and Social Workers.
- *Headspace*, provides early intervention mental health services to 12-25 year olds, along with assistance in promoting young peoples’ wellbeing (four core areas of mental health, physical health, work and study and alcohol and other drug services). Headspace provides access to co-located services and external referral to General Practitioners, psychologists, social workers, alcohol and drug workers, counsellors, vocational workers or youth workers. Clients often require referral from a General Practitioner and an assessment by an intake worker who connects the client to services, based on their need.
- *The King’s Fund*, a UK charity working on improving the health care system in England. The King’s Fund encourages integrated models of care, reporting at length on the benefits and challenges of integration, and highlighting integrated models of care already in practice (e.g. Kaiser Permanente United States, Nuka System of Care Alaska, Gesundes Kinzigtal Germany, Counties Manukau New Zealand, Jonkoping County Council Sweden, Sandwell Integrated Primary Care Mental Health and Wellbeing Service).
- *Sandwell Integrated Primary Care Mental Health and Wellbeing Service*, a holistic primary and community care-based approach to improving social, mental and physical health and wellbeing. The client is guided through the service via a care coordinator, who can provide referral to these providers (as opposed to requiring referral from a General Practitioner). The service uses a stepped care approach, whereby the

client is continually assessed for their needs and tailored care packages created, based on these individual needs.

- *Oran Park Family Health*, an Integrated Primary Care Centre established via a partnership between South Western Sydney Local Health District, South Western Sydney PHN and University of Western Sydney. The clinic provides access to primary, allied and community health care through co-location and integration of services. The clinic intends to provide streamlined access to health care, with a single entry point and a multidisciplinary, coordinated team providing wraparound care for patients.

Integrated models of care have been adopted across the world because of their perceived benefits both to consumers and the system. The World Health Organisation (2007) recommends the integration of mental health services into primary health care because of the following advantages:

1. Reduced stigma for people living with mental health disorders and their families when seeking mental health care from a primary care provider (as opposed to a stand-alone specialised service).
2. Improved access to mental health services and treatment of co-morbid physical conditions.
3. Improved prevention and detection of mental disorders, as primary health care practitioners are often the first point of contact for individuals. Upskilling primary health care workers in mental health skills promotes a more holistic approach to patient care, ensuring improved detection and prevention of mental health issues.
4. Providing treatment at a primary care level, backed by secondary health care and informal community care, can prevent people from being admitted into hospitals and psychiatric institutions, by providing continued, wrap around, responsive care to the patient.
5. Improved human resource capacity for mental health by sharing workload and expertise, and by coordinating care.

► Systemic Challenges of Integrated Service Delivery and Value of the Proposed Model

The benefits of integrated models of care are obvious, however, there have been very few attempts to adopt this model in NSW. Despite the advantages, it would be naive not to consider the challenges of implementing such a model in NSW. These include, but are not limited to:

1. Financial and time investments required to train staff and coordinate services.
2. Reluctance of providers to participate in integration and coordination.
3. Capacity for General Practitioners to treat patients living with mental health conditions.
4. No policy or planning between Commonwealth and State Governments, so that there are two different approaches to mental health funding and service delivery that often act separately.

Many of these challenges are associated with an existing system that is highly siloed and fragmented, resulting in some providers not having the capacity or willingness to participate in integration and coordination. Currently, health care is funded through both the Commonwealth and State Governments separately, with little coordination between the two. In addition, there is a further divide between public and private services, creating confusion over what is available and how to access these, as well as, competition between the various providers. The proposed model is a new approach to addressing these issues at a micro level, by bringing together State, Commonwealth public and private services, and supporting General Practitioners in treating patients that present with severe mental illness.

Evaluating the successes and challenges of integrated models trialed locally and overseas provides valuable insight to the integrated mental health service model being proposed.

► Results and Discussion

The *Integrated Mental Health Service Project* was successful in developing a single, agreed model for a trial integrated subspecialty clinic, providing coordinated, wrap around care and appropriate referral for people living with severe and persistent mental illness. The model describes what services the proposed clinic could provide and how it may function. How it may be implemented and resourced is also described as a guide.

► Service Model

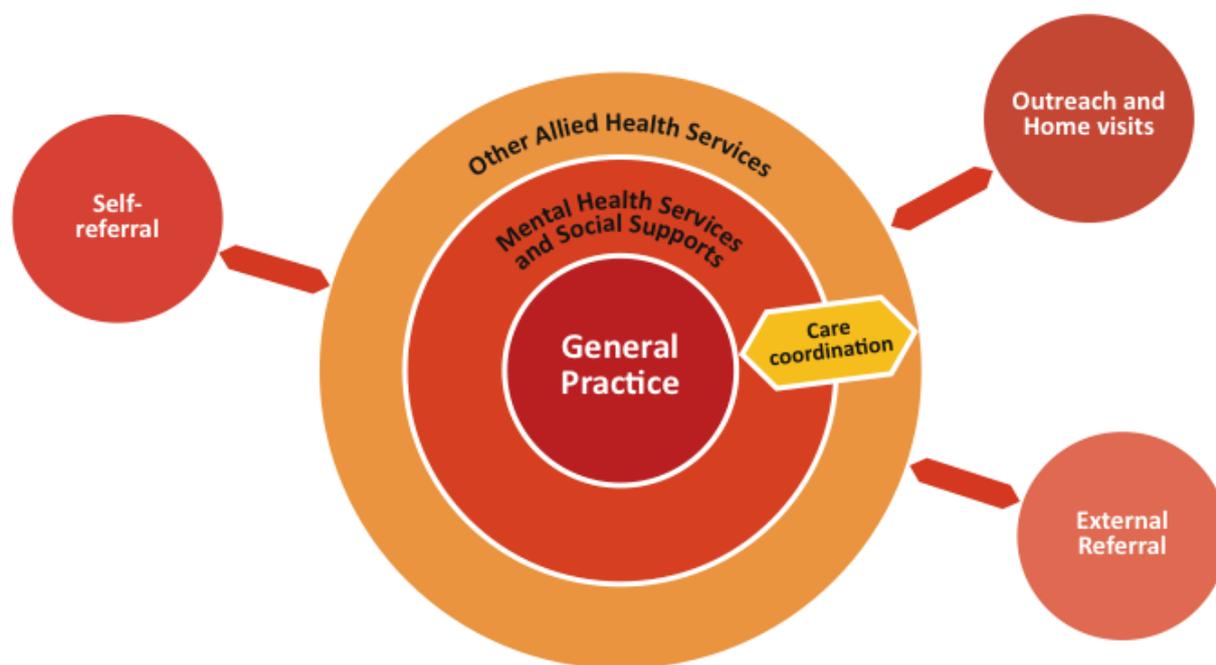
The Service Model (see diagram)

The model is for an integrated sub-specialty clinic within a General Practice that delivers wrap around clinical care, care coordination and appropriate referrals for people living with severe mental illness. This means integration and coordination across various levels of care, including:

- Horizontal integration and coordination of mental health care within primary health care.
- Vertical integration within the mental health system (i.e. between primary, secondary and tertiary mental health services).
- Vertical integration and coordination within the broader health system (i.e. between primary mental health services and secondary and tertiary physical health services).
- Horizontal integration with the non-health sector (i.e. social support services).

General Practitioners and primary care services play a key role in the treatment and care of people living with severe and persistent mental illness (The Mental Health Commission of NSW 2014). General Practitioners have the capacity to monitor and support interventions aimed at the physical health of people living with mental illness, and have a responsibility to address the mental health needs of people presenting with physical health issues (The Mental Health Commission of NSW 2014). General Practitioners are often the first point of contact for people seeking health care, and is the preferred discharge point for patients exiting Community Mental Health. However, consultation with General Practitioners in South Western Sydney have highlighted the need for greater support for General Practitioners in treating patients living with severe and persistent mental illness. For these reasons, the model places the General Practice at the center of the service, benefiting from the General Practitioners wide repertoire of skills and expertise, and their ongoing relationship with the patient, whilst utilising specific knowledge and supports from specialised health and community services.

It is recommended that the clinic include colocation of key primary, mental health, other allied health and support services, with the option of external referral, telemedicine, outreach services and home visits. Clients may also self-refer themselves through any of the services provided, so that once they enter the system (from any touch point) they are provided streamlined access to any or all the services they may need. This would be coordinated through a single intake system, tailored care plans and the allocation of a coordinator of care (further discussed in **Service Coordination**).



Priority Services

The service model is intended to be a public-private hybrid, bringing together the public and private health system that currently exists. This means access for clients to a combination of private business/practitioners and publicly funded services (further discussed in **Resourcing**). During consultation with key stakeholders, potential services were prioritised based on the common needs of people living with severe and persistent mental illness in South Western Sydney.

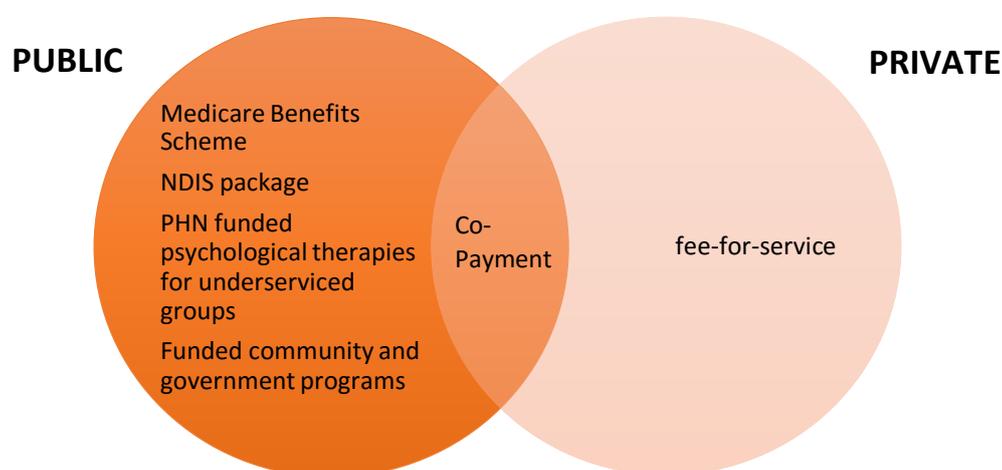
Consultation participants saw traditional mental health services (i.e. psychologists and psychiatrists) as most important to be located within the clinic or easily accessible from the clinic. Consultation of General Practitioners showed that these types of clinical mental health services were currently preferred in the treatment and support of people living with severe and persistent mental illness (90% preference for psychologists and 86% preference for psychiatrists). Therefore, it is recommended that as the foundation for the mental health subspecialty, clinical mental health services be included as a priority. It was suggested that in order to increase accessibility, the clinic also offer the option of telemedicine. Approaches to telemedicine have been trialed through the Wollondilly Health Alliance and this presents as an opportunity to inform this model.

In addition, the service should provide easy transition between the clinic and Community Mental Health. Again, Community Mental Health was highlighted as the currently preferred avenue for treatment and support of people living with severe and persistent mental illness by General Practitioners (41%). A depot clinic (particularly administering clozapine) was also seen as important for people living with severe mental illness. More specifically consumers highlighted the difficulties in accessing and managing these medications, and therefore emphasised the value of an easily accessible service to receive depot medication.

A variety of social supports were suggested during consultation, with a particular focus on drug and alcohol support, family support, employment, housing and homelessness. Although it was acknowledged that not all social support services could be co-located within the clinic, consultation participants stressed the importance of these services being easily accessible (either walking distance, through outreach/home visits or via public transport). A streamlined referral pathway, and care coordination, is vital to ensuring the client is able to navigate through what support services are available to them, and transition into these services easily.

Other allied health services suggested predominantly focused on those assisting people in managing the side effects of medication and the physical health risks of severe and persistent mental illness. Again, key services would ideally be co-located within the clinic or be easily accessible. Key allied health services included dietitians, generalist counselling, occupational therapists, exercise physiologists and access to a pharmacy (to provide management of medications and education). Smoking management, diabetes education and nutrition programs were suggested as additional educational programs important in supporting clients in preventing and managing physical health issues often associated with severe mental illness.

Throughout, it was stressed that services needed to be easily accessible and affordable. It was preferred that health services be bulk billed and/or subsidised considerably for clients who are unable to pay full fee, with the option of full fee payment if the client can afford to do so. The pie chart below shows the various funding and payment options for the client to access:



Service Location

There were mixed opinions on where the trial clinic should be located. Most services and practitioners based in Campbelltown pushed for the clinic to be located within Macarthur, due to high density, easy access to public transport and availability of a large range of existing services. In contrast, Wingecarribee and Wollondilly were seen as having the most need for such a service, and a relatively large, although dispersed, population. As a suggested 'middle ground', Tahmoor was proposed as a site location, with existing health centres and mental health services located in close proximity, and access to public transport with its own train station (see **South Western Sydney Local Health District map**).

A number of General Practices were engaged during consultation and expressed interest in participating in the model. 54% of General Practitioners expressed interest in participating in the model, and 90% of community services, mental health practitioners and other allied health practitioners expressed interest in participating in the model. Ultimately, the location of the service would greatly be determined by the location of the practice intending to adopt the model, and the availability of key services willing to participate in the model. Determining this would be important when commissioning the establishment of the trial clinic, noting that the model can be replicated in other areas.



Strengths of the Model

Based on previous attempts at similar models of integration, and the experiences of those consulted, there appeared to be significant strengths to the proposed model:

- General Practitioners are typically the first point of contact for an individual, a consistent member of a client's health care team, and preferred point of discharge for Community Mental Health, therefore the General Practice is well placed to drive the model. The service model acknowledges this by placing the General Practice at the center of it.
- Service integration and coordination saves money and time for both clients and services, by pooling resources and expertise, and creating a more efficient system of working with other practitioners and treating the client (The Mental Health Commission of NSW 2014; World Health Organisation 2007).
- The model allows practitioners and services to access and utilise a range of supports and knowledge, so that the client can be provided appropriate, holistic care based on their individual needs.
- The model creates streamlined pathways of care and reduces fragmentation of services through a single referral system, shared medical records and care coordination.
- Two-way referral between mental health, primary health, other allied health and social support services mean that the clients health and social needs are addressed together. This results in better health outcomes for the client overall.
- A public-private hybrid maximises on available resources so that the service is affordable for clients.

Weaknesses of the Model

As with any model however, there are perceived weaknesses of the proposed service, including:

- In South Western Sydney, the model is theoretical and has not yet been practically adapted. However, evidence from other attempts nationally and globally show promise. Learning from these attempts, adapting the model to a local context and establishing a trial service which is regularly evaluated will ensure the service is responsive to the needs of the local community and works as is intended.
- The model requires care coordination and integration to be funded for it to work successfully. This may include financial incentives for services and practitioners to participate in the model, funding to implement information sharing systems and the employment of a care coordinator. The financial model should consider these costs when the project is commissioned.
- The model is based around primary health care, and therefore may seem too clinical in nature, compared to a model that is based around community health and social services. Consumer/Carers who were consulted expressed concern in the service feeling too clinical.
- The primary purpose of the subspecialty clinic is to treat and support people living with severe and persistent mental health. It was expressed that this may create a gap for people living with less severe mental health issues. In reality, this clinic and its services may be accessed by anyone (through referral from a service or self-referral). The clinic would also form part of a series of commissioned services funded by the South Western Sydney PHN, and will work within the stepped care model adopted by the PHN.
- Some consultation participants felt concern over General Practitioners being central to the model, as it was perceived that General Practitioners are not as well equipped (in knowledge, understanding, time and resources) to work closely with people living with severe and persistent mental illness. It was suggested instead that this role be taken by a mental health nurse based within the clinic. Although mental health nurses may be important in the assessment and support of people accessing the service, the General Practitioner plays an important role in overall health assessments and the ongoing care of the client. Therefore, the integration of a General Practitioner and mental health nurse is the strongest model to ensure a range of client needs are met.

Service and Agency Roles

A number of key services and agencies would need to be involved in the development, implementation and management of the proposed clinic. These include:

- The South Western Sydney PHN, who will be responsible for considering the potential commissioning of the model (and other associated projects), overseeing its implementation and evaluating on its successes and challenges.
- The South Western Sydney Local Health District which will provide treatment and services to patients within the hospital or Community Mental Health, who may also be a client of the clinic. Community Mental Health may refer discharged patients to the clinic and work with the clinic on developing and implementing the patient's care plan, so that there is a smooth transition and continued care when a patient is discharged from Community Mental Health.
- Community services can refer clients to the clinic and receive referrals from the clinic itself. It is expected that these services would provide social supports to clients based on their social needs. A relevant service may also take the role of care coordination and case management, replicating existing models of care coordination and case management currently being used to support people living with severe mental illness.
- Private and publicly funded health professionals (e.g. General Practitioners, psychologists and psychiatrists) would provide clinical care and treatment of clients. As such, they will also be involved in the care planning and care coordination of individuals.
- The New South Wales Government and Commonwealth Government (particularly through the Health Departments) could provide funding towards the establishment, management and growth of the clinic and its services.
- Local Governments already engage with the community, and therefore, can provide feedback on community needs to the service, so that it may be responsive to these needs.

► Service Co-ordination

The Coordination Model

Coordination of services and client care will be fundamental for integration to be effective. The diagram below illustrates potential pathways of coordinated client care.



At the point of referral into the clinic for issues relating to severe and persistent mental illness, the client is assessed by an intake nurse to determine service provision, based on the client's needs and urgency. Following this initial assessment, the client may be provided a coordinator of care. The coordinator of care is responsible for conducting referrals, providing support to the client in accessing services and engaging with the client and other practitioners to develop person centered, holistic care plans. The care coordination role may not necessarily be associated with a specific profession (although mental health nurses, social workers, care coordinators and case managers have been suggested during consultation), but rather a particular set of skills; including interpersonal skills and a deep knowledge of the sector.

Peer Support Workers are also critical in drawing on their lived experience of mental health issues and recovery to provide ongoing emotional and social support as a client undergoes the recovery process. In 2016, The Mental Health Commission of NSW launched the *Peer Worker Hub*, based on recommendations from the *Living Well Report* (The Mental Health Commission of NSW 2014). The program encourages organisations to embed person centered, recovery oriented and trauma-informed approaches in mental health services, by creating a peer workforce within the service (The Mental Health Commission of NSW 2016). The Hub may provide the tools to inform the development of a peer workforce within the proposed service.

A single referral system attached to a shared record system will allow streamlined referral and communication between providers. Examples of such systems include:

- *South Western Sydney Local Health District Integrated Electronic Medical Record*, supports client management from referral to discharge and onward referral where appropriate. The system provides access to fast, real time information to support decision making and provides electronic access to client clinical history, reducing reliance on paper records. The South Western Sydney Local Health District's Community Mental Health may utilise this system to aid in the transition of patient care from Community

Mental Health into primary care. Such shared information systems aid coordination between providers, and would complement the currently proposed service model.

- *My Health Record*, is a national online medical record system controlled by patients and contributed to by any health practitioner with the access to do so. Currently, My Health Record is an opt-in only system, whereby patients must set up and share their own account. However the Government is looking to adopt an opt-out participation method instead. This would mean an already funded single medical record system that could be utilised by the clinic.
- *No Wrong Door*, aims to create streamlined referral pathways through an online portal, which can be utilised by workers to find support for people in a more coordinated and sufficient way. Organisations must opt-in to gain access to the portal and any organisation (as opposed to just health professionals) may participate, even if mental health is not their core business.

All services must commit to care coordination for the model to be effective. The model involves care delivery by a multidisciplinary team, and if these teams can work cooperatively and cohesively with each other and the client, there will be better physical and mental health outcomes for the patient. Care coordination of services also achieves the pooling of funds, resources and knowledge for the benefit of both the client and the services themselves.

Finally, case conferencing and coordination meetings, involving practitioners, service heads and relevant staff will provide opportunities for providers to discuss specific or complex cases, and plan service delivery for these clients. They also allow practitioners to consult with each other on certain issues, for example, a General Practitioner can consult a psychiatrist on the mental health issues experienced by their patient.

In order to be effective, care coordination should involve an agreed process and assessment of client care, whereby, the client should be consulted on their needs and what they wish to achieve from treatment, and this be integrated into their care plans. Therefore, the client should be at the center of their vision for their care and should be involved in developing agreed outcomes or goals for their care (for example, Partners in Recovery Personal Wellness Wheel Model). Initial and ongoing assessment and accurate management plans are crucial to providing relevant care that is flexible, responsive and holistic.

Barriers and Solutions to Co-Ordinated Care

There are several barriers to providing effective coordinated care, which often contributes to the aversion of services to adopt integrated, coordinated models of service delivery. These barriers include:

- Availability of practitioners to be involved in coordination. General Practitioners surveyed during consultation highlighted that a major barrier to participating in this model is their availability of time to dedicate to treatment and care coordination of people living with severe and persistent mental illness.
- Lack of funding and/or incentive to coordinate care.
- Competition between providers, 'ownership' of information and similar attitudes that create service fragmentation and silos.

Recommended solutions to such barriers, some of which have been used by other attempts of integration, include:

- Dedicated funding to support care coordination. This should be considered within the commissioning and financial planning of the project.
- The care coordinator role should be independent as opposed to being associated to any particular organisation, so that coordination is not biased and the position remains even if an organisation leaves the partnership or loses funding.
- Participation of services in care coordination as a requirement to partake in the model. This condition should be detailed in any MOUs between services and considered in the commissioning approach by the South Western Sydney PHN.

- Direct referral pathways and shared information systems that aid care coordination by streamlining and simplifying client referral between services and practitioners.
- Ongoing review of care coordination that ensures barriers and issues that arise can be swiftly addressed. This means that care is responsive and coordination is continuously improving.

It is important to note that care coordination already exists in varying degrees within and between services and providers. The proposed model simply builds on a currently well accepted and established method of service delivery.

► Governance Model

The governance model suggested in the diagram below is much like that of similar models of integration such as *LikeMind* and *Oran Park Family Health*. This is a consortium, whereby the model is managed by a lead agency and services agree to participation in the model through a memorandum of understanding. It is hoped that over time the clinic will eventually become its own legal entity, similar to community mental health models established in Victoria.

It is anecdotally clear from attempts at simple co-location of services (without any investment in integrating systems and coordinating care), that merely co-locating services is not enough to achieve true integration. Therefore, services need to commit to an overarching governance model, through formal agreements and a memorandum of understanding. These agreements should detail the conditions of participation, including their obligation to participate in true integration and coordination. The clinic itself should also form agreements with tertiary health services, for example South Western Sydney Local Health District Community Mental Health, and partnerships with external services. Ultimately, participation in the service delivery model could become a condition of funding from Federal, and ideally State, Governments so that providers are funded to participate in the model.

Consortium Governance Model



► Resourcing

In order to be successful, an initial level of significant investment will be required. Potential resource needs and avenues for funding were discussed during the consultation and co-design process. As with any new or existing practice, a robust financial model is required to ensure private practitioners generate income and profit. In addition, because of the public-private structure of this model, further funding is required to sustain public services. The financial model will therefore consider the income/expenditure of the private practice itself and any additional private practitioners, and consider the costs associated with integrating and coordinating publicly funded services.

Funding for this model can be accessed from the following income streams:

- *National Disability Insurance Scheme* funding, by services becoming registered NDIS provider.
- *Medicare Benefits Scheme*, to subsidise General Practitioners and other practitioners so they may provide bulk billed services. General Practitioners may receive incentives for creating mental health plans and reviewing these plans for the patient. Maximising on available Medicare funding will encourage General Practitioners and other practitioners to treat people presenting with mental illness, and will allow patients to access affordable services.
- Maximising on existing South Western Sydney PHN commissioned Services. For example, *You In Mind* which provides access to psychological therapies for underserved groups diagnosed with mild to moderate mental illness and *Credentialed Mental Health Nurse Service* which broadens access to mental health nurses across South Western Sydney.
- Current and new Local, State and Federal Government funding that may be accessed by community services to fund programs delivered through the clinic.

Resource Needs

Briefly, there will be specific costs associated with developing the trial subspecialty clinic around an existing practice. Some of these resource considerations include:

- Incentives for Practitioners (particularly General Practitioners) to participate in model.
- Resources for services to co-locate to the existing practice.
- Funding for care coordination and integrated systems.
- Funding for practitioners and services so that they may provide affordable and accessible services to clients.

A Public-Private Hybrid

The current mental health system combines public and private services that may be accessed by consumers, however, these services often operate in their own siloes as opposed to integrating and maximising on each other's available resources. The proposed model acknowledges the nature of the current system, but rather integrates public and private services in a public-private hybrid. On the surface merging public and private services may seem complex and confusing for both services and clients; given their different income streams and consequent fee options for clients who utilise those services. However, if adopted successfully, the public-private hybrid model has a number of strengths:

- Firstly, the hybrid model closes the gap between the private and public sector that, unavoidably, already exists. As a result, the model achieves true integration of the current mental health system. This is more relevant to the context of mental health service delivery in Australia.
- In addition, as highlighted above, the public-private hybrid allows the clinic to access a greater variety of funding packages based on individual service structure and funding needs, meaning more available income streams for those who participate in the model.

► Alternative Models

During the consultation and co-design process, a number of participants suggested alternative models of service delivery, based around community health. This included building on the existing South Western Sydney Community Mental Health service by incorporating a service integration model into the Community Mental Health structure. This alternative model neglects to consider the ultimate purpose of Community Mental Health, highlighted during consultation with the South Western Sydney Local Health District. The structure of Community Mental Health specifically targets those at an acute stage, with preference for patients to be discharged to a General Practice for continued care. The currently proposed model acknowledges the place for Community Mental Health within the stepped care model, and the importance of building the capacity of primary health to treat people living with severe mental illness.

A similar 'community health' model was proposed whereby community services are central to the model, rather than the General Practice at the center. Again, the currently proposed service model aims to support General Practitioners in the treatment of people living with severe mental illness (an issue expressed by General Practitioners during consultation), as the principal point of contact for consumers to the health system. In addition, consultation with General Practitioners found that General Practitioners do not typically utilise social support services in patient treatment, and the current model encourages the use of these social support services by integrating these services into the governance and operations of the practice. Therefore, the General Practice is best placed at the center of the model, with other relevant services connected to it. Although the project acknowledges that there are various models for integrated service delivery, the model best meets the objectives of the South Western Sydney PHN and fits into the context of mental health service delivery in South Western Sydney.

► Conclusion and Next Steps

The *Integrated Mental Health Service Project* provides valuable insight on the implementation of integrated service delivery in South Western Sydney. The proposed service model described in the following report has been developed with significant engagement from key stakeholders in South Western Sydney, and feedback was generally consistent and the initial model well accepted, with additional recommendations. Should the South Western Sydney PHN choose to commission this service, the following conditions are recommended to aid in the successful implementation and maintenance of the project.

Recommendations for Commissioning

1. Identify a General Practice interested in participating in the delivery of the service model and integrate services into an existing practice.
2. Co-locate key mental health, allied health and social support services around/within the practice, with the additional option of telemedicine, external referral, outreach services and home visits (see **Service Model**).
3. Establish a consortium of services that are participating in the model, and develop governance structures that support it (see **Governance**).
4. Develop a robust financial plan that considers resource needs, and maximises on existing potential income streams and available resources (See **Resourcing**).
5. Fund service coordination, including a care coordinator role and service participation in coordination (see **Service Coordination**).
6. Incentivise service and practitioner participation in the model, particularly through maximising on available funding and resources (e.g. Medicare Benefits Scheme, other South Western Sydney PHN Commissioned Projects and Local, State and Federal funding).
7. Develop shared information pathways, including appropriate IT systems (see **Service Coordination**).
8. Create agreements that ensure integration and coordination are a condition of service participation in the model.
9. Undergo continuous evaluation and improvement of the model so that it is flexible, appropriate and responsive to service and client needs.
10. Ensure streamlined pathways and coordination with Community Mental Health.

The *Integrated Mental Health Service Project* has significant implications for the primary and mental health system, beyond the scope of South Western Sydney. If implemented successfully, the service can reduce inefficiency and waste, and improve the health outcomes of consumers (The Mental Health Commission of NSW 2014). Therefore, it is recommended the South Western Sydney PHN explore, further, the commissioning of the Integrated Mental Health Service.

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