INTEGRATED MENTAL HEALTH SERVICES
Approx. **10% of 18+ olds** in CESPHN have high levels of psychological distress (NSW average 8.4%)

**12.5% of CESPHN** population experience mental illness & behavioural issues (NSW average 13.1%)

**Capacity** doesn’t match demand; GPs **under resourced** to adequately manage mental health in primary care

**Lack of coordination** between providers in various settings

**Services delivered in isolation** and cater for single need - **no multi agency** response

**Unclear Referral pathways**, eligibility criteria

**Lack of coordination** at transition points; one size fits all approach

**Lack of effective communication with and involving carers** and family members in service provision, care planning and decision-making
THE TARGET GROUP

- Children and Young People (0-25 years);
- Women experiencing prenatal/postnatal depression;
- People who identify as Aboriginal and/or Torres Strait Islander;
- People from Culturally or Linguistically Diverse (CALD) backgrounds;
- People who are at risk of suicide or self harm.
WHAT IS REQUIRED

- Person-centric integrated / coordinated approach to care / service delivery
- Centrally managed referral process
- Streamlined assessment
- Needs based service allocation, with flexibility
- Ability to incorporate multiple service offerings as required
- Funding for outcomes not inputs
- Delivered in the context of a person’s journey through the care continuum
- Delivered consistently across the population
STEPPED APPROACH
REFERRAL PATHWAY

- A single point of assessment
- Centrally manage the referral and admission process
- Allocate clients to providers from external organisations
- Standardise processes and data collection.

ENABLING

Better access to and timely provision of services to clients

Ability to flex services to changing needs

Funding for outcomes and compliance with governance frameworks.
CONNECTING THE DOTS...

• Partnership with consortia of service providers and community based organisations

• Providers to demonstrate their capacity and capability to respond to the needs of vulnerable, hard to reach people

• Focus Mental Health Nurse on:
  – the transition from hospital care to GP and community care
  – supporting GPs to provide improved care to people with severe and persistent mental illness with complex support needs, to avoid hospitalisation
  – providing a holistic approach to primary healthcare i.e. coordinated care planning and delivery
SERVICE COORDINATION

Service Coordination Modules
- Service Request
- Service Delivered
- Service Agreement
- Service Catalogue
- Budget and Financial Dashboard

Patient
- Service Request
- Service Delivered
- Service Agreement
- Service Catalogue
- Budget and Financial Dashboard

Care Plan

Service Catalogue

Service Agreement

Patient Financial Dashboard

Category
- Services

Contracted Services
- Provider
- Cost

Patient Budget
- Committed
- Spent
THE FUTURE

- Personalised Shared Care Plans
- Self Management Support
- Multi Disciplinary Teams
- Technology enabled Case Conferencing for specialist and MDT input
- Report on outcomes against the agreed care plan
CRITICAL SUCCESS FACTORS

• We have to lead the whole system for the whole system to change...
• Put the patient at the centre
• Analysis without paralysis – this is about leadership and learning

Start now and start with partners!
You will ultimately go further, faster together