



## **PROJECT PROPOSAL**

**The design, trial and evaluation of *Recovery & Wellbeing Locals*:  
One-stop shops in the community for mental health recovery,  
improved health & wellbeing and social inclusion**

## Précis

The Mental Health Coordinating Council proposes the conduct of a project to develop, trial and evaluate a new service model, namely, *Recovery & Wellbeing Locals*. It is proposed that the trials be conducted over three and a half years and be conducted in three areas in NSW: an urban area, regional area and rural or remote area.

*Recovery and Wellbeing Locals* are envisaged as being partnership-based one stop shops with the purpose of:

establishing processes for the coordination of multi-disciplinary responses to a person's physical health, mental health and social and emotional needs.

*Recovery and Wellbeing Locals* will target people with mental illness or mental health problems who irrespective of their psychiatric diagnosis have high levels and complex sets of mental health, physical health, personal and social needs. Access to the different service systems will be coordinated from the one familiar place rather than people having to go from service to service, from referral to referral and through multiple intake processes. In this way, *Recovery and Wellbeing Locals* will assist to prevent people with high levels of needs from either falling through the gaps in services or giving up their search in the face of inaccessible, unaffordable or unresponsive services.

By addressing physical health care needs, mental health needs, recovery and social needs in a coordinated way under one roof, *Recovery & Wellbeing Locals* will trial a new model of integrated, whole of person approach to service delivery for people with mental illness or mental health problems who have complex service and care needs.

The MHCC will oversee and manage the project and will engage through open tender, community-managed mental health organisations to coordinate and oversee the establishment of *Recovery and Wellbeing Locals*. The contracted community-managed mental health organisations will take responsibility in their local area for a number of key tasks including:

- The employment of salaried support workers, peer support workers and a practice nurse;
- The establishment of partnerships and processes locally to ensure that people with mental illness or mental health problems with complex needs have more ready access to the services they require;
- The engagement of or establishment of service agreements with private practitioners to provide psychological services and primary health care through various Medicare-based programs and schemes;
- The establishment of service agreements with local service providers including among many, Centrelink, Housing NSW and employment services to conduct in-reach and outreach sessions at the *Recovery and Wellbeing Local*; and
- The development of innovative solutions to clusters of significant local needs.

In particular, the *Recovery & Wellbeing Locals* will facilitate and ease access to Medicare-based psychological, primary health and allied health care services; services that many people with mental illness and mental health problems despite their eligibility and despite their high levels of need are currently not accessing.

It is proposed that the project be independently and externally evaluated and that the evaluation commence with the project's outset.

A total project cost over the three and half years of **\$4,554,000** is proposed.

## Introduction

*Scenario One – I've handled some pretty tough situations. But nothing had prepared me for the how hard getting over depression is. I don't want to leave the house, I don't want to see people. All the things I did so easily I can't do anymore. Talk about being de-skilled. I've got no confidence. I'm losing my friends and my family is even getting to the point of giving up on me. They are sick of my hopelessness. I've put on so some much weight. On top of everything I've just been told I have diabetes. The doctor says I need to change my diet and exercise but I don't feel I can. I missed my last appointment and feel too ashamed to make another one. The doctor wants me to have tests for other things. I guess they can wait. Life seems such a mess. The list of things I need to do keeps getting longer but I just can't do anything of it.*

*Scenario Two – I'm never really well when I'm discharged from hospital after a psychotic episode. I'm still quite shaky. I'm better than I was but I'm still struggling with the old psychosis. Some days it is not so bad other days I feel like it is cranking up a bit. It's hard to concentrate, I haven't got much motivation and everything seems hard. I am shaky about a lot of things not least of all the traumatic events I experienced during the episode. I want to be out of hospital but I have so many things to do when all I want to do is stay in my house. I get panic attacks at the thought of going outside the front door and I know I would get more attacks if I went into public places like the supermarket or bus stop. The case manager wants me to go the GP or come back to hospital and have my health checked ... and have the dizzy spells checked out. I haven't seen a GP for years – can't afford to. But I don't want to go near any medical person. People are still pretty angry with me because of what happened before I was admitted to hospital.*

Here are two scenarios reported frequently by community managed mental health organisations. The first portrays a person with psychosis who is struggling to recover after a period of hospitalization; the second, a person struggling with depression. Both people despite their differing conditions, one a low prevalence condition, the second a high prevalence condition, have high levels of social, emotional and personal needs. Both are isolated and struggling with recovery. Their lives have contracted to within the walls of their house. Both seem to have potentially serious physical health conditions developing. One has a GP whilst the other hasn't. The one who has a GP struggles to make and keep appointments. Further, both have many things to do which might include taking care of Centrelink, banking, rental or Department of housing, legal, family and relationship issues. And that's without listing all the day-to-day things they need to do to get through a day.

In recent times, member organisations, consumers, carers and communities have talked to the MHCC about the need for one-stop-recovery shops where people with high levels of social, emotional and personal needs can walk into a friendly, low keyed setting and find the assistance they require whether it be information and referral, psychosocial support, medical and primary health care, health promotion, Centrelink payment related etc. Envisaged is an environment like that provided by Neighbourhood Centres, where people can go, feel comfortable, be linked to all the different types of services they require and have a worker who can coordinate their care and liaise with all of the other services providers. The concept is one of access to as many services as possible under one roof, of services providers conducting outreach or in-reach sessions on-site, hence reducing the number of different locations people must go back and forth between.

Developing and trialing processes for a one-stop-shop recovery model for people with mental illness who have high levels of social, emotional, personal and health care needs is timely given the imminent establishment of Medicare Locals (or primary health care organisations) and Health and Hospital Networks, the expansion of access to psychological services under the Better Access and similar schemes and expanded opportunities for coordinated care.

This proposal comprises the following sections:

- Section One:** The concept of Recovery and Wellbeing Locals
- Section Two:** Project Proposal
- Section Three:** Relevant policies, frameworks and strategies; and
- Section Four:** Relevant programs for enabling access to psychological and primary health care services through Medicare.

## 1. The concept of *Recovery & Wellbeing Locals*

In view of the rapid growth of the community-managed mental health sector and in an effort to focus efforts on accessible, relevant, high quality and coordinated programs for people who need mental health support, the Mental Health Coordinating Council recently undertook a mapping project of the sector. The report of this project (MHCC 2010) identified the following seven core community-managed mental health service areas or functions that need to be accessible within each local area:

- Accommodation Support & Outreach;
- Employment & Education;
- Leisure & Recreation;
- Family Support & Carer Programs;
- Self-help and Peer Support;
- Helpline & Counselling Services; and
- Information, Advocacy and Promotion.

The Recovery & Wellbeing Locals, led by the community-managed mental health sector, would seek to make available all of these service functions to people with mental illness and/or mental health problems who have complex needs. In addition, the recovery and Wellbeing Locals would seek to facilitate assistance with health care and social needs.

Recovery & Wellbeing Locals will establish processes for the coordination of multi-disciplinary responses to a person's physical health, mental health and social needs.

### 1.1 The envisaged purpose of *Recovery & Wellbeing Locals*

*Recovery and Wellbeing Locals* are envisaged as community managed mental health sector-partnerships for the purpose of establishing one-stop-recovery-shops to:

- support mental health recovery;
- improve mental health and emotional wellbeing;
- improve physical health;
- support healthy lifestyles;
- improve social wellbeing; and
- enhance social inclusion.

*Recovery and Wellbeing Locals* will assist people who irrespective of their psychiatric diagnosis have complex sets of mental health, physical health, personal and social needs. By assisting people with mental illness or mental health problems with complex

needs, the Recovery and Wellbeing Locals will assist people who often fall out of service, who are lost to service systems or who fail to obtain services until a late stage.

Access to the different service systems will be coordinated from the one place, a community managed mental health organisation, being a familiar place where people with complex needs feel comfortable. Rather than people having to go from service to service, from referral to referral and through multiple intake processes, initial contact with the services they require will occur through that familiar place. In this way, *Recovery and Wellbeing Locals* will provide a bridge for people with mental illness or mental health problems with high level of needs to access the services they require in a timely and coordinated fashion. The Recovery and Wellbeing Locals will seek to ensure access to overcome problems associated with inaccessible, unaffordable or unresponsive services.

In particular, the *Recovery & Wellbeing Locals* will facilitate and ease access to Medicare-based psychological, primary health and allied health care services; services that many people with mental illness or mental health problems who have complex needs are currently not accessing despite their eligibility

Taking the lead in reaching out to those with high levels of needs, community-managed mental health organisations will be able to use their knowledge of local communities to target population groups who frequently encounter road blocks to psychosocial and recovery support, psychological services and health care services including Aboriginal and Torres Strait Islander peoples, CALD communities including refugees and recently settled groups, homeless people, people with co-existing disability, gay, lesbian and transgender people and families having experienced transgenerational abuse, trauma and disadvantage. In this way, Recovery and Wellbeing Locals will be able to target local needs and tailor responses to the different needs of local groups. They will also be able to have a proactive role in identifying and seeking to respond to newly emerging needs.

## **1.2 Target groups**

*Recovery and Wellbeing Locals* will target people with mental illness or mental health problems who have high levels of social, emotional, personal and health care needs and who by reason of their complex sets of needs are at risk of mental health relapse, stalled mental health recovery, poor physical health, isolation and social exclusion.

Whether a person has a high prevalence or low prevalence primary psychiatric diagnosis is not the determining issue. Rather, the key criterion is complexity of person's service and care needs. For example, Scenario One above portrayed the situation of a person with depression, a high prevalence condition. Depression is having such severe impacts that the person is at risk of further decline both physically and mentally. Attending to daily tasks let alone accessing psychosocial support, psychological services through Better Access, primary health care and assistance with Centrelink or legal issues under his or her 'own steam' has become far too difficult.

The person portrayed in Scenario Two has a primary diagnosis of a psychosis, a low prevalence disorder. As with the person with depression, this person's mental condition is having severe impacts and is disrupting the person's life. Like the person with depression, the person with psychosis is finding it too difficult to access the services and assistance he or she requires. The person with psychosis like the person with depression would benefit from psychological services available through the Better Access. A psychologist would be able to work with the person on overcoming and managing panic. If the panic could be better managed, the person would be more confident to leave his or her house. However, the benefit for people with psychosis of treatments available through Better Access and similar schemes are often not

understood resulting in many missing out on valuable and life improving services. Many people, like the person portrayed in Scenario Two, with a primary diagnosis of psychosis experience high levels of anxiety, depression and post traumatic stress disorder which severely impact on their lives and can lead to drug and alcohol misuse disorders. Learning how to manage depression and anxiety and receiving assistance with PTSD, would assist the recovery of many people with psychosis as well as assisting greater engagement and participation in the community. The Recovery and Wellbeing Locals would assist people with high levels of need to access psychological services as well as psychosocial and recovery support.

In both scenarios, the people concerned have health care needs and problems that are currently not being addressed or sufficiently managed. Both would benefit from multidisciplinary care that is available through Complex Care Plans. However, both are currently struggling to stay engaged with or to seek the required services through primary health care. The Recovery and Wellbeing Locals will support and assist people with high levels of need to better access and to stay engaged with primary health care

### **1.3 Services to be accessible through the Recovery and Wellbeing Locals**

Through community-managed mental health sector partnerships and working relationships, the *Recovery & Wellbeing* Locals will facilitate access to the range of psychosocial and recovery support services provided locally including those identified above: Accommodation Support & Outreach; Employment & Education; Leisure & Recreation; Family Support & Carer Programs; Self-help and Peer Support; Helpline & Counselling Services; and Information, Advocacy and Promotion

Partnerships will be developed with a number of health care service providers including Divisions of General Practice, local GPs, psychiatrists and a range of individual allied health practitioners to offer psychological and primary health care through a range of Medicare rebates. Wherever possible and practicable, the services of these professionals will be provided onsite at the *Recovery & Wellbeing Local*.

Services to be provided by or through the Recovery & Wellbeing Locals include the following.

**Care and service coordination** – a coordinated system of intake, assessment and planning in collaboration with each person and key service providers to ensure that the right services are available and brought together in a way to meet assessed and agreed needs.

**Psychosocial rehabilitation and recovery support services** - a range of services, including social, emotional and personal support, practical support to live at home, support in housing, employment and education and training, social activities, peer delivered services and support, helping link people with services and advocating on their behalf.

**Psychological services** – services accessed through contractual arrangements with private practitioners accredited and registered with Medicare Australia to provide PBS/MBS items including psychological treatments and therapies, focused psychological strategies, trauma support and other psychological services;

**Primary health care** – clinical health care services provided by GPs, as well as by practice nurses, primary/community health care nurses, early childhood nurses, community pharmacists and a range of other allied health professionals including physiotherapists, psychologists, dieticians, speech therapists, occupational therapists, dentists and other oral health etc. Support to access specialist health care will also be provided.

**Health promotion and preventative health & wellbeing services** – services to prevent illness and further ill health and to promote physical and mental health and healthy living.

**Direct links to services, agencies and groups supporting social inclusion** – including:

- *Access to income* – Centrelink, financial counselling, assistance with debt payment, Emergency Relief etc;
- *Secure and affordable housing* – Department of Housing, Community Housing, SAAP, HASI, Tenancy Advice and subsidies and supports available through Centrelink;
- *Employment* – Job Services Australia, JobSearch, local employment service providers, supported employment programs, Job Capacity Assessment, Centrelink etc;
- *Education & training* – local training programs and training opportunities, TAFE & higher education;
- *Assistance with transport* – access to locally-based community transport schemes and subsidies;
- *Legal services* – legal advice, assistance with specific legal issues e.g. family law, child support, domestic violence, consumer law etc
- *Family support* – Family & Care Support Program, family support and counseling services e.g. Family Relationship Services, Child Support Agency, Family Assistance
- *Recreation, leisure & participation* – opportunities to engage in a wide range of community activities and aspects of community living.

A key component of this proposal is the establishment of processes for care coordination of the person's recovery including their physical health, mental health and social needs. While community mental health workers will coordinate psychosocial and recovery support, it is proposed that a practice nurse be employed as a salaried member of staff. A major role of the practice nurse will be to liaise with private practitioners and to coordinate access for service providers to primary health care and psychological services through Medicare rebates in a timely and integrated fashion. The practice nurse will provide onsite health screen checks primarily, and routinely, for cardiovascular risk factors such as weight and blood pressure and will coordinate the development of locally relevant and viable primary health promotion strategies. The practice nurse will work with service users to support them to adopt lifestyle risk modification, self-management strategies and tools to monitor their complex health care needs.

By providing access to all of these services under one roof, *the Recovery and Wellbeing Locals* will assist to remove some of the significant barriers experienced by people with high levels of social, emotional, personal and health care needs including:

- difficulty in finding information about available services;
- difficult to navigate complex referral pathways and service systems;
- stigma and discrimination;
- communication difficulties;
- travel costs and other out-of-pocket costs; and
- difficulty in locating and accessing bulk-billing primary health and mental health professionals.

By addressing physical health care needs, mental health needs, recovery and social needs in a coordinated way under one roof, *Recovery & Wellbeing Locals* will trial a new model of integrated, whole of person approach to service delivery for people with mental illness or mental health problems who have complex service and care needs.

#### **1.4 Outcomes to be sought by the *Recovery & Wellbeing Locals***

Outcomes sought by *the Recovery & Wellbeing* locals include improved mental health and social and emotional wellbeing, improved physical health, reduced morbidity and mortality arising from preventable physical illness and greater participation in the community. More specifically, outcomes sought will include:

- More people with mental illness and mental health problems who have complex needs having a GP, having regular comprehensive health check-ups and receiving a full range of primary health care services;
- Earlier diagnosis and treatment of physical health care problems;
- Earlier and more timely access to specialist services when required;
- Greater engagement of people with complex service and care needs in preventative health, health promotion and healthy lifestyle programs;
- Improved disease self management of physical illness by people with complex service and care needs;
- Sustained recovery through coordinated and timely support with day-to-day living and through peer support;
- Improved social circumstances through stable, secure and affordable housing, assistance with income and financial issues, employment opportunities and training and education opportunities;
- People with complex service and care needs obtaining access to psychological services to assist with depression, anxiety and trauma associated with their mental illness or mental health problems and with other difficulties including relationship stress, drug use disorders, alcohol use disorders;
- People with complex service and care needs staying actively engaged with clinical mental health services and continuing with treatment; and
- Earlier assistance and reconnection with clinical mental health services were a person to begin to relapse.

The *Recovery & Wellbeing Locals* will also seek to improve care coordination and to build stronger and more diverse partnerships between providers of psychosocial and recovery support and providers of primary health, community health, preventative health and health promotion and clinical mental health and alcohol and drug services. Better coordination and improved partnerships will also be sought with those agencies whose services are frequently required by people with high levels of needs including Centrelink, Department of Housing, Community Housing, SAAP, Department of Community Services and Job Services Australia.

#### **1.5 The imperative for recovery locals**

The literature on mental health recovery emphasises the importance of nurturing the whole person and all aspects of the physical, emotional and social wellbeing. The literature points to a number of concepts that interact and facilitate the recovery journey for people living with mental illness. These include:

*taking control of one's own life, understanding one's illness, developing a healthy lifestyle, social supports, nurturing the whole person and social inclusion. Social inclusion is a central component of recovery, whereby a person's social context must be considered in the maintenance of wellbeing and health. (MHCC 2009:4)*

An integrated service delivery approach of this nature is not commonly experienced by people with mental illness or mental health problems who have complex service and care needs. Rather many experience difficulty in accessing the care and treatment they require for a backlog of physical health needs and many go without psychological therapies which could enhance treatment being received from public, and in some instances private, mental health services. In the face of urgent physical or mental health needs, a person's

mounting personal and social needs can be neglected. The *Recovery & Wellbeing Locals* will seek to avert this process and to support a person to take control of their life inclusive of their mental health care, physical health care, emotional and social needs.

*Recovery & Wellbeing Locals* will seek to contribute within a local area to addressing the health inequities experienced by people with high levels of social, emotional, personal and health care needs. Both Australian and international research for over a decade has demonstrated that people with mental illness are more likely than others to have significant health risks and major health problems (Brown et al 2000; Connelly & Kelly 2005; Harris & Barraclough 1998; Lawrence et al 2003; Woo et al 2008). People with mental illnesses are more likely to die younger than others and more likely to experience illness like strokes, respiratory disease, cancer, diabetes and coronary heart disease (Lawrence et al 2003; Newcomer 2007; Osborn et al 2006 & 2008). They are also more likely to experience these illnesses earlier and before the age of 55, are less likely to survive for more than five years following diagnosis and are less likely to receive through primary care some of the expected, evidence-based checks and treatments (Scotland Government 2005; UK Disability Rights Commission 2006).

Recent research from the UK and Scotland demonstrates the extent of the greater morbidity rates for specific groups of people with mental illness (Scotland Government 2005, 2008; UK Disability Rights Commission 2006). For example, in a UK study, women with schizophrenia were found to be 42% more likely to experience breast cancer than other women in the general population and that people with schizophrenia, both men and women, were 90% more likely to get bowel cancer (UK Disability Rights Commission 2006).

The research clearly demonstrates that people with mental illness experience greater health risks factors such as obesity, smoking, poor nutrition, limited recreation and physical exercise and social exclusion (reference).

More recently evidence is emerging about the poor oral health of people with mental illness and the impact of this on both their overall physical and mental health.

The research indicates that the causes of this greater morbidity and mortality among people with mental illness are multiple and include social deprivation, lifestyle, problems with access to and affordability of health assessments, treatment and care and the side effects of anti-psychotic and mood stabilizer medications. (Holt et al 2005; UK Disability Rights Commission 2006; Scotland Government 2005). The research indicates that where specific physical conditions have been identified, people with a mental illness are at risk of receiving poorer treatment than the general population (Frayne et al 2005; Kisley et al 2007). Recent UK research shows that people with schizophrenia and heart disease have fewer blood pressure or cholesterol tests than people with heart disease but who do not have serious mental health problems. Similarly, people with schizophrenia who had experienced a stroke were found to have had fewer cholesterol tests than other people with stroke.

A phenomenon of 'diagnostic overshadowing' has also been reported in the literature. This occurs when reports of physical symptoms and poor ill health are viewed as being part of a person's mental illness resulting in an underlying physical illness not being identified and treated at a sufficiently early point. (UK Disability Rights Commission 2006)

The adverse effects of some psychiatric medications have also been found to cause poor physical health. Anti-psychotic medications can give rise to metabolic disturbance, major weight gain and obesity, heart problems, diabetes, blood pressure changes, osteoporosis, and involuntary movement disorders. Instances of sudden death have also been reported in the research (Frayne et al 2005; Harrison 2004; Connolly & Kelly 2005; Fenton & Stover 2006; Osborn et al 2006; Woo et al 2008). Anti-depressants are a risk factor for heart disease (Osborn et al 2008).

The research also indicates that efforts to target the higher health risks of people with mental illness and to address their physical health care needs are at best ad hoc (Kisley et al 2006). Positive policy and practice developments have not become part of either mainstream mental health care or mainstream primary health care (UK Disability Rights Commission 2006).

Both Scottish and UK government reports indicate that, despite the low expectations of clinical staff, health promotion interventions do work and that people with serious mental illness will avail themselves of these interventions. (Keep Well Scotland) The research provides solid support for specifically targeting two groups. Firstly, targeting evidence based-health promotion and lifestyle support at those with mental illness who are at greatest risk of poor health is indicated (Scotland Government 2005; 2007; 2008;UK Disability Rights Commission 2006). Secondly indicated is the targeting health promotion to those who have just been diagnosed with mental illness so that from the outset of treatment, opportunities are provided to access structured health and well being promotion measures such as regular health checks and screens, nutritional advice, structured weight management, recreation and physical activity, assistance to quit smoking and information on the risks and benefits of psychiatric medications and about how the risks to health can be mitigated or best managed (NHS Quality Improvement Scotland 2007; Scotland Government 2005;2007;2008).

The research indicates the need for embedding the management and treatment of physical health and well being for this population group within existing health improvement policies and practices and within mental health services themselves (Leucht & Fountoulakis 2007;Marder et al 2004: Mental Health Council of Australia 2004; NICE 2010).

‘Improving the management of physical health and well being for people with a mental illness should be embedded within existing health improvement policies and practice, and health promotion, screening, self-management and recovery initiatives must be equally available to all’. (29)

The concept and proposed operation of Recovery & Wellbeing Locals is informed by specific interventions suggested in the research for people with serious mental illnesses include the following.

- *General health and wellbeing review:* - taking account of lifestyle choices such as smoking, diet, physical activity, and risk behaviours such as alcohol and drugs, with appropriate health promotion advice and interventions offered (McCreadie et al 2005; Scotland Government 2005; UK Disability Rights Commission 2006).
- *Additional health promotion activity* - Giving attention to immunisation needs, sexual and reproductive health, dental needs and eye checks (Scotland Government 2005)
- *Medication management* - A routine review of any side effects with action where appropriate (Harrison 2004; Woo et al 2008).
- *Physical screening* – Primarily, and routinely for cardiovascular risk factors such as weight and blood pressure (Barnett et al 2007; Cohn 2006).
- *Investigations* - primarily and routinely for cardiovascular risk factors such as glucose and cholesterol (Woo et al 2008).
- *Facilitation of collaborative and comprehensive health care* – facilitating appropriate health care and structured systems for conducting, recording and monitoring health screenings and investigations and developing collaborations with GPs, inpatient services, community mental health services, dieticians, dentists, physiotherapists, recreational and occupational therapists, recovery support providers, diabetes and other medical specialists as indicated (Leucht & Fountoulakis 2007).

- *Multidisciplinary training to reduce the risk of 'diagnostic overshadowing'* – encouraging all mental health professionals to view physical health as being fundamental to improved mental health, to be aware of the increased health risks experienced by people with mental illness and to actively seek to identify health problems early and to reduce and prevent poor physical health (Scotland Health 2008).
- *Improved prescribing, monitoring, information and choice in relation to psychiatric medication* – greater vigilance among clinicians in relation to the potential for medication-related metabolic side effects such as weight gain and glucose irregularities and to ensure frequent monitoring from the outset as well as assistance with weight management and mitigation of the risks to health (Cohn et al 2006; Leucht & Fountoulakis 2007; Scotland Government 2005; 2007).
- Benchmarking, setting targets and outcome and performance measurement – Research and community surveying undertaken in Scotland and the United Kingdom pointed to the need for benchmarking of excess morbidity and mortality in people living with mental illness and to then set targets for reducing the major health inequities. Scotland has moved to requiring health services and mental health services to report against benchmarks and targets and to monitor and report on the evidence based health improvement interventions that they have developed and implemented (Scotland Government 2005; UK Disability Rights Commission 2006).

Finally, the literature shows the importance of the direct involvement of people living with mental illness in shaping and leading the development of evidence based health promotion and improvement policies and services. *The Recovery & Wellbeing Locals* will seek to engage service users in developing promotion and prevention strategies and programs that are relevant and viable locally and are able to draw on local resources.

## 2. Project Proposal

It is proposed that a trial be conducted of a small number of Recovery and Wellbeing Locals in NSW. The MHCC will oversee and manage the project and will engage through open tender, community-managed mental health organisations to coordinate and oversee the establishment of Recovery and Wellbeing Locals. The contracted community-managed mental health organisations will take responsibility in their local area for a number of key tasks including:

- The employment of salaried support workers, peer support workers and a practice nurse;
- The establishment of partnerships and processes locally to ensure that people with mental illness or mental health problems with complex needs have more ready access to the services they require;
- The engagement of or establishment of service agreements with private practitioners to provide psychological services and primary health care through various Medicare-based programs and schemes;
- The establishment of service agreements with local service providers including among many, Centrelink, Housing NSW and employment services to conduct in-reach and outreach sessions at the Recovery and Wellbeing Local; and
- The development of innovative solutions to clusters of significant local needs.

It is proposed that the project be independently and externally evaluated and that the evaluation commence with the project's outset.

### 2.1 Aims of the Project

The major aim of the project is to develop, trial and evaluate *Recovery & Wellbeing Locals* in three areas in NSW: an urban area, regional area and rural or remote area.

*Recovery and Wellbeing Locals* are envisaged as being partnership-based one stop shops with the purpose of:

providing or facilitating access to 'whole of life', 'whole of person' wrap-around services to support mental health recovery, improved health and wellbeing and social inclusion.

*Recovery and Wellbeing Locals* will target people with mental illness or mental health problems who have high levels and complex sets of mental health, physical health, personal and social needs. Access to the different service systems will be coordinated from the one familiar place rather than people having to go from service to service, from referral to referral and through multiple intake processes. In this way, *Recovery and Wellbeing Locals* will assist to prevent people with mental illness or mental health problems either falling through the gaps in services or giving up their search in the face of inaccessible, unaffordable or unresponsive services.

In particular, the *Recovery & Wellbeing Locals* will facilitate and ease access to Medicare-based psychological, primary health and allied health care services; services that many people with mental illness and mental health problems despite their eligibility and despite their high levels of need are currently not accessing. These schemes and provisions include but are not restricted to:

- *Access to Allied Psychological Services (ATAPS)*, part of the *Better; Outcomes in Mental Health Care (BOiMHC)* funded via GP Networks
- *Better Access to Mental Health Care*;
- *Chronic Disease Management ('Enhanced Primary Care') Program*;
- Allied Health Group Services under Medicare for patients with type 2 diabetes;
- *National Mental Health Nurse Initiative*;
- *Mental Health Services Rural and Remote Program*;
- *Multidisciplinary Case Conference*;
- *Domiciliary Medication Management Review*;
- Nurse Practitioner rebates;
- Expanded opportunities for Comprehensive Care Packages.

.An overview of each of these initiatives and potential relevance to the proposed Recovery and Wellbeing locals are provided in Section 4 below.

## **2.2 Project's governance and stakeholder input**

The MHCC will be the project's lead agency and will coordinate the project and provide governance and accountability. The MHCC proposes to establish a small Project Steering Committee comprised of representatives from a number of key stakeholder groups. The Steering Committee will assist with the development of strategic partnerships, policies, guidelines and protocols that are essential for the project's good governance and success.

The MHCC also proposes to provide opportunity for a wide range of further stakeholders to be involved with the project via Reference Group. Stakeholders to be involved in this way will include but not e restricted to:

- MHDAO;
- Representatives of member organisations;
- NSW CAG;
- Individual consumers;
- Key carer and family organisations;
- Individual carers;
- NSW Mental Health Transcultural Network;

- Aboriginal Health and Medical Research Council of NSW;
- Network of Alcohol and Other Drug Agencies;
- General Practice NSW;
- NSW Branch RANZCP;
- NSW Branch Australian College of Mental Health Nurses;
- NSW Branch College of AASW;
- NSW Branch Australian Psychological Association;
- NSW Branch of OT Australia;
- NSW Branch College of Nurse Practitioners;
- NSW Centre for Rural and Remote Mental Health
- NSW Division Royal Flying Doctor;
- Centrelink;
- NSW Housing; and
- Individuals or organisation with relevant expertise.

### **2.3 Project's conduct & phases**

It is proposed that the project run for 3.5 years and comprise the following phases.

#### **Phase 1 Establishment Phase of the Project (Months 1-6)**

Key tasks will include:

- Establishment by the MHCC of a Steering Committee and a Reference Group;
- Formation by the MHCC of partnerships to guide the project's conduct;
- Employment by the MHCC of a Project Coordinator;
- Development by the MHCC of possible service models;
- Development by the MHCC of protocols, guidelines, templates, databases and other;
- Development by the MHCC of request for Tenders or Expressions of Interest documentation; call for tender proposals or Expressions of Interests from partnerships lead by a community managed mental health sector organisation; selection of successful bids; signing off on contractual arrangements with each successful tender; and working with successful partnerships to finalise individual project implementation plans;
- Development by the MHCC of request for tenders documentation for the project's evaluation; selection of successful tenderer; and finalisation of evaluation plans.

#### **Phase Two: Development and establishment Phase of Recovery & Wellbeing Locals (Months 7-14)**

During this phase each of the partnerships will establish the *Recovery & Wellbeing Locals* in their areas. Major tasks will include:

- Publicising the project locally by contracted community-managed mental health organisations;
- Establishment local Steering and Reference Committees by the contracted community-managed mental health organisations;;
- Employment by the contracted community-managed mental health organisations of Site Project Coordinators & Practice Nurses;
- Each site seeking expressions of interests from locally-based primary health and mental health practitioners who are accredited with Medicare Australia and who are interested in providing services through the Recovery & Wellbeing local;
- Selection of practitioners and establishment of contractual arrangements and service agreements at each site by the contracted community-managed mental health organisation;

- Establishment at each site of MOUs or service agreements with locally-based primary health providers, mental health services and psychosocial and recovery support organisations;
- At each site call for Expression of interest to provide in reach sessions or outreach programs e.g. Centrelink, local employment services, TAFE, Financial Counselling services, Child Support Agency, Department of Housing, Diabetes Educators etc;
- Introduction and implementation of referral, intake, assessment procedures at each site;
- Development of care coordination procedures, protocols and enabling information systems at each site;
- Setting in place at each site project data systems;
- At each site meeting with Evaluation team and setting in place the systems that are required for Project Evaluation;
- Purchasing or hiring of necessary equipment at each site;
- Launch and opening of the Recovery & Wellbeing Local at each site.

### **Phase Three: Fully operational Phase (Months 14-42)**

During this phase the *Recovery & Wellbeing Locals* will provide access to primary health and psychological services and will continue to develop new programs and initiatives. Six monthly reports documenting progress, activity, outcomes, learning and issues will be provided by each site. The evaluation team will provide a report on a 12 monthly basis as well as an overall project evaluation report towards the completion of the project.

During this period MHCC and the project sites will discuss with key stakeholders continuation or expansion of the Recovery Locals following the completion of the project phase.

#### **2.4 Possible service models**

Possible service models will be explored in detail during the establishment Phase of the Project. The models will build on the experience to date of NGO's contracting or providing access to Medicare-based primary health and psychological services (discussed in section 4.10 above). The models will also draw on the experience of Headspace, Divisions of General Practice, the College of Mental Health Nurses, the Flying Doctor Service and the Centre for Rural and Remote Mental Health in purchasing or contracting the services of Medicare-based primary health care and psychological services.

#### **2.5 Staffing requirements, profiles, experience and roles and responsibilities**

The proposed staffing requirements, profiles, experience and roles and responsibilities are now outlined.

**Overall Project Coordinator (FTE)** – employed by and based with the MHCC to coordinate the project' conduct, implementation and evaluation; a person with significant project management expertise and experience in working community mental health organisations and providers of primary health care and who has an understanding of relevant Medicare programs and schemes.

**IT, Administrative and Project Support (2 FTE)** – people with a mix of IT, administrative and project support expertise and experience with working with community agencies; employed by and based with the MHCC to provide IT and administrative support services to the project; to help the MHCC and each site to set in place consistent administrative, information systems and data recording & reporting systems; and to trouble shoot where required.

**Project Coordinator at each site (1 FTE)** – a person to be employed by and based with each of the contracted organisations; responsible for coordinating the conduct,

implementation and evaluation of the project locally and initiating local partnerships, contractual arrangements and service agreements; with similar expertise and experience as that of the Overall Project Coordinator.

**Support worker at each site** (1 FTE) – a suitably qualified and experienced person to be employed by and based with each of the contracted organisations to be responsible for care coordination, for the provision or facilitation of access of project service users to the required mental health and recovery support; for ensuring each service user obtains the assistance they require from other service providers; and for troubleshooting service access difficulties for individual service users.

**Peer support workers at each site** (1 FTE – 2 part-time) – suitably experienced people to be employed to provide peer support to project service users and to develop programs that enhance the social and emotional wellbeing of service users.

**Practice Nurse** (1 FTE) – a nurse trained professional with expertise and experience in working with community organisations and with initiating primary and preventative health care programs; responsible for initial intake and assessment, routine physical health checks, liaising with local health services, mental health services, providers of primary health care and providers of psychological services and developing or coordinating health promotion and preventative health programs; a key player alongside a person's clinical mental health case manager, psychosocial support and recovery worker and GP in care coordination and planning;.

**Admin/reception at each site** (1 FTE) – a suitably experienced person to be employed by and based with each contracted organisation to provide administrative and reception services for the Recovery and Wellbeing Local and to assist with data recording and reporting.

## **2.6 Data recording and reporting**

Consistent with the directions, principles and policies outlined in the recent *NSW Community Managed Mental Health Sector Data Management Strategy Report: Phase One* (MHCC 2010b), the Project Coordinator based with the MHCC will oversee the development and establishment of consistent data and information systems across the project and each project site, including the *Routine Consumer Outcome Measurement (RCOM)*. Six monthly reports against agreed outcomes will be required from each site. An evaluation report will be received on a 12 monthly basis and as well as at the conclusion of the project.

## **2.7 Evaluation**

As stated above, the evaluation will be contracted out to an independent and appropriately provider through an open tendering process. The evaluation will commence with the commencement of the Project.

Key questions to be investigated via qualitative and quantitative methods during the evaluation will include:

- What was the perceived need or drivers that motivated the introduction of the project locally?
- How have the purpose of the project and the role of the Recovery & Wellbeing Locals been interpreted and/or implemented in the different sites? What factors influenced this?
- What service model(s) have been implemented at each site?
- What have been the establishment and sustainability challenges? What strategies have assisted with overcoming or minimising these?
- What partnerships and working relationships have been built and how?

- What have been the outcomes for consumers and how did consumers assess the service and assistance they received?
- What successes has the project achieved? What has contributed to these?
- What were the project's limitations? What contributed to these limitations?
- What are the ongoing challenges and what might assist with overcoming these?
- What are the opportunities for enhancement?

Key inquiry and research domains are summarized in the following table.

<b>Domains</b>	<b>Areas to investigate</b>
Commencement	Perceived need, establishment, time operational
Auspice body	Type of organisation, governance arrangements, partners in the project
Location of program	Region covered, population demographics
Workforce	Employment model, Size of program, Capacity
Service Models	Role of salaried staff; role of providers of Medicare-based primary health & psychological services; where they provide services, management, clinical support & supervision; referral, intake and assessment processes
Implementation, evolution of project	
Partnerships	Service provision; Care Coordination Strategies
Clients and carers	Access; Demographics, involvement in treatment plans, Diagnosis/es, outcomes for consumers and their families and carers
Service provision	Service Activity levels; Outcomes; Impact on demand
Quality mechanisms	Clients; agency & partnership; Providers of primary health and psychological services
Program themes	Strengths, enablers, barriers, opportunities & issues, areas for improvement

It is likely that at least five data collection processes will be conducted across the project sites throughout the project:

1. An initial project site survey of partnership and stakeholders;
2. Stakeholder consultation in each of the three project sites at the 12 month, 24 month & 36 month stage;
3. Client survey at points to be determined;
4. Annual snapshot of service data collection at each project site (e.g. services provided across a week);
5. Overall service, client and outcome data analysis

In addition, information about the project and the concept and utility of Recovery & Wellbeing Locals will be sought from a range of national and state-based stakeholders.

Evaluation reports will be received on a 12 monthly basis and as well as at the conclusion of the project.

## 2.8 Milestones & Timelines

The following milestones and timelines are proposed.

Task	Milestone	QPC	Date completed
Establish project governance arrangements & arrangements for stakeholder input	Steering Committee and Reference Group established with TORs and commenced meetings	MHCC Board satisfied with governance arrangements & both the Board and MHDAO satisfied with inclusiveness of Reference Group and with the opportunities for stakeholder input	End 1 <sup>st</sup> Six months
Employment of Project Coordinator & IT & Project Support Officer	Project Coordinator & IT & Project Support Office employed and commenced work	MHCC employment policies and procedures followed	End 1 <sup>st</sup> Six months
Tender process conducted to engage community-managed mental health organisation at 3 sites to establish the RWLs	Community-managed mental health organisations engaged and contracts executed	Process complies with best practice open tendering	End 1 <sup>st</sup> Six months
Tender process conducted to engage an external & independent evaluator	Evaluator engaged & contract executed	Process complies with best practice open tendering	End 1 <sup>st</sup> Six months
Service models and protocols, guidelines, templates & database established	Project operating manual inclusive of models, protocols, guidelines, templates complete and ready for implementation; database ready for implementation	Sign off by Steering Committee of major items	End 1 <sup>st</sup> Six months
Establishment local Steering and Reference Committees by the contracted community-managed mental health organisations	Steering Committees and Reference Groups established with TORs and commenced meetings	MHCC satisfied with arrangements; arrangements comply with contractual requirements	End 14 months
Employment by the contracted community-managed mental health organisations of staff for their Site	Staff employed at each site and fully operational	Community-managed sector employment P&PS complied with	End 14 months
Introduction and implementation of referral, intake,	Referral, intake and assessment processes	Reviewed by external and independent evaluator	End 14 months

Task	Milestone	QPC	Date completed
assessment procedures at each site	operational		
Establishment at each site of MOUs or service agreements with locally-based primary health providers, mental health services and psychosocial and recovery support organisations	Service agreements & MOUs in place and local service provides providing services	Comply with all legal requirements; consistent with contractual advice, guidelines & templates provided by MHCC	End 14 months
MOUs with service providers in place at each site for in-reach sessions or outreach programs e.g. Centrelink, local employment services, TAFE, Financial Counselling services, Child Support Agency, Department of Housing, Diabetes Educators etc	MOUs in place and in-reach and outreach sessions being conducted by a range of service providers		End 14 months
Development of care coordination procedures, protocols and enabling information systems at each site	Care coordination arrangements in place & operating	Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	End 14 months
Setting in place at each site project data systems	Data systems in place and working effectively	MHCC & contracted agencies satisfied with efficacy	End 14 months
At each site meeting with Evaluation team and setting in place the systems that are required for Project Evaluation	Evaluation arrangements in place and proceeding	Steering Cttees review positively	End 14 months
Purchasing or hiring of necessary equipment at each site	Sites equipped	Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	End 14 months
Launch and opening of the Recovery & Wellbeing Local at each site	RWLs launched	Steering Cttees review positively; Reviewed by external & independent evaluator; consumer and other key stakeholder	End 14 months

Task	Milestone	QPC	Date completed
		review positively	
RWLs established and providing access to mental health and social support, psychological services & primary health care	RWLs fully operational	Reviewed by external & independent evaluator; consumer and other key stakeholder review positively	By end first 14 months
Six monthly reports by Project sites	Six monthly progress and activity report produced by contracted organisation at each site	Sign off by local Steering Committee; complies with contractual requirements;	Six monthly from 12th month
12 monthly evaluation reports & final project evaluation report	Evaluation reports prepared 12 monthly at conclusion of the project	Evaluation report prepared to the satisfaction of MHCC Board, overall Project Steering Committee & MHDAO	At 12 month, 24 month, 36 month & 42 month stage

## 2.9 Project costs

Proposed project costs are outlined in the following table. A total project cost of **\$4,554,000** is proposed.

ITEM	RATE/FEE	ITEM COSTS
<b>Salaries</b>		
Overall Project Coordinator	\$100,000 per ann for 3.5 years (inclusive oncosts)	\$350,000
IT, Admin & Project Support	\$50,000 per ann for 3.5 years x 2 (inclusive oncosts)	\$350,000
Site Project Coordinators (3 FTE)	\$100,000 per ann for 3 years x 3 sites (inclusive on-costs)	\$900,000
Site Support Workers (3 FTE)	\$60,000 per ann for 3 years x 3 sites (inclusive oncosts)	\$540,000
Site Peer Support Wkrs (3 FTE)	\$60,000 per ann for 3 years x 3 sites (inclusive oncosts)	\$540,000
Site Practice Nurse (3 FTE)	\$85,000 per ann for 3 years x 3 sites (inclusive oncosts)	\$765,000
Site Admin & Reception (3 FTE)	\$50,000 per ann for 3 years x 3 sites (inclusive oncosts)	\$450,000
<b>Equipment</b>	\$15,000 per site	\$45,000
<b>Project Evaluation</b>		\$200,000
	<b>Sub total</b>	<b>\$4,140,000</b>
	GST of 10%	\$414,000
	<b>Total costs</b>	<b>\$4,554,000</b>

### 3. Relevant policies, plans & strategies

There a number of national and state-based policies and strategies that like the proposed *Recovery & Wellbeing Locals* are seeking to achieve better coordination of and integration of health and community services and better health outcomes at a local area. The proposed Recovery & Wellbeing Locals has relevance to the directions and implementation to a number of these policy frameworks including:

- The new national health reforms;
- National Preventative Health Strategy;
- 4<sup>th</sup> National Mental Health Strategy; NSW Community Mental health Strategy 2007-2012;
- Development within the community-managed mental health sector in NSW; and
- Linking physical and mental health initiative (MHDAO NSW)

The relevance of the proposed Recovery and Wellbeing Locals to each of these policies is discussed in turn.

#### 3.1 The new national health reforms

A key aim of the national health reforms is the better coordination and integration of health services at the local level through establishment of a National Health and Hospital Network comprised of Local Hospital Networks (LHN) and closely aligned Primary Health Care Organisations (PHCO) or 'Medicare Locals' responsible for coordination of health services within local regions. These newly created LHNs and Medicare Locals will generally align with each other in terms of geographic coverage and will be broadly based on the existing Divisions of GPs servicing between 250,000 and 500,000 people. Details on size and distribution are due December 2010. Initial operation of Medicare Locals will commence in July 2011 with a transition for full operation scheduled for June 2012.

Under the new arrangements the Commonwealth Government will take full funding and policy responsibility for general practice and primary health care services. This includes services currently provided by states and territories, including community health centre primary health care services, primary mental health care services which target mild to moderate mental illness, immunization and cancer screening programs. The implications of this for mental health services are complicated for many reasons including the variation in how different states have structured mental health hospital and community services.

It is also unclear where the NGO mental health sector will fit in this new picture. The proposed *Recovery & Wellbeing Project* Proposal may provide a timely opportunity and vehicle to explore this question and to ensure that linkages and working relationships between the mental health NGO sector and the new Medicare Locals and Local Hospital Networks are developed as early as possible. A further contribution of the proposed *Recovery & Wellbeing Locals* would be the development and trial a strategies of local care coordination and for enabling NGOs, primary health service providers etc to work together to coordinate care of people with complex physical health, mental health and recovery needs.

A further relevant initiative for which Medicare Locals will assume responsibility is the expanded *Flexible Care Packages*. In the 2010-2011 Commonwealth Budget, the Australian Government provided \$58.5 million over four years to deliver new packages of coordinated care to better support up to 25,000 people with severe mental illness being managed in primary care, to be delivered through Access to Allied Psychological Services arrangements. Medicare Locals, once established, will be the fundholders for the care packages. The Recovery & Wellbeing Locals will provide a mechanism for the community-

managed mental health sector to assist people with high needs to access these packages and for the sector to be involved with the implementation of these new packages.

### **3.2 National Preventative Health Strategy**

One of the functions of Medicare Locals will be to deliver health promotion and preventative health programs targeted to risk factors in their local communities. These organisations will be supported in this role by the Australian National Preventive Health Agency, which will take the lead on implementing the National Preventative Health Strategy. This new agency will provide national standards and guidelines to support the roll-out of effective and appropriate programs in the initial priority areas of obesity, alcohol and tobacco. People with mental illness have been identified as a priority population group in the area of reducing tobacco use and preventing health related harm.

The Australia Government is supporting primary care to deliver better preventative health outcomes through a number of measures including:

- providing an additional \$449.2 million to fund better coordinated care for individuals with diabetes, to improve management of their condition and make sure they stay healthy and out of hospital; and
- making available additional funding of \$390.3 million over four years to boost support for nurse positions in general practice – this initiative will support nurses to undertake a broad range of prevention activities, such as health assessments, health promotion and advice, educating patients on lifestyle issues, and managing recall and reminder systems.

Once the Preventative Health Agency commences there will be a number of funding programs and initiatives which the mental health NGO sector might be able to access including health living programs, Quit Smoking training and programs specifically for people with mental illness. A key role for the new proposed Recovery & Mental Health Locals is the establishment of regional partnerships to support innovative holistic health prevention and promotion programs for people with mental illness and mental health problems. Given this role, the *Recovery & Wellbeing Locals* would be ideally situated to seek funding from programs initiated by the Preventative Health Agency.

### **3.3 The Fourth National Mental Health Strategy**

The plan has five priority areas for government action in mental health:

1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, coordination and continuity of care
4. Quality improvement and innovation and
5. Accountability - measuring and reporting progress.

The proposed Recovery & Wellbeing Locals Project is well aligned with the following key actions of the Priority Area 3 – Service Access, coordination and continuity of care:

- Establish regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities.
- Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.
- Improve linkages and coordination between mental health, alcohol and other drug, and primary care services to facilitate earlier identification of and improved referral and treatment for mental and physical health problems.

- Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant.
- Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.

It is possible that new national funding programs supporting these key actions will emerge during the life of the 4<sup>th</sup> Plan.

### **3.4 NSW Community Mental Health Strategy 2007-2012**

Building on and linking to the *New Directions for Caring for Mental Health* in NSW and the *Framework for Rehabilitation*, the *NSW Community Mental Health Strategy* provides a framework for service and workforce development and for the development of strong partnerships. Importantly it provided a vehicle for discussion with the community-managed mental health sector about directions for the sector to move forward. This proposal to develop and trial the service model of Recovery & Wellbeing Locals, links directly to some of the key outcomes being sought by the NSW Community Mental Health Strategy, namely partnerships enabling innovation and collaboration in planning and service delivery.

### **3.5 Development within the community-managed mental health sector in NSW**

As discussed above, the *NSW Community Managed Mental Health Sector Mapping Project* identified seven core community-managed mental health service functions that should ideally be available in each local area. With an increased shared understanding of its role, the community-managed mental health sector is well placed to embark on the proposed project to establish the Recovery and Wellbeing Locals. This new service model will enable the sector to establish processes and partnerships for working towards providing access to each of the seven core functions locally.

### **3.6 Linking physical and mental health initiative (MHDAO NSW)**

Many NGOs have already made the connection between physical and mental health and have incorporated this into their programs. The importance of linking physical and mental health care is also being acted upon by NSW Health in their current initiative to work collaboratively with other health care providers, particularly General Practitioners (GPs), to improve the physical health of people who use a mental health service. This initiative provides a further opportunity for NGOs to draw on the information and resources provided by NSW Health, and promote physical health to consumer clients and /or develop allied programs.

A key feature of the initiative has been the release of a policy directive for Area Mental Health Services in NSW outlining their responsibilities to ensure the consumers who use their service have access to physical as well as mental health care. A set of guidelines (Physical Health Care of Mental Health Consumers) has been developed which gives practical advice to staff about how these responsibilities could be met.

A complimentary project is one being run through PRA who received and allocation of funds through the *Chronic Disease Self-Management Lifestyle and Risk Modifications Grants Program* to create the *Back On Track Health (BOTH) Project*. The BOTH Project is designed to promote early intervention and active participation in self-care management to significantly enhance the physical health of people living with a mental illness who are service users of PRA. The project is providing a program of care coordination and is developing primary health promotion strategies. It is also support service users to adopt risk modification, self-management strategies and tools to monitor complex health care needs. An Occupational Therapist was engaged to establish the project and two registered nurses were employed as health advisors for 6 months to assist the project to develop policies and health resources, including the 'My Health Needs Checklist', 'My Health

Questions Wallet Card' and the 'My Green Book' health record for service users. A Health Services Directory and pre and post health surveys were also developed with data collected to be incorporated into PRA's database.

NEAMI has also embarked on a health promotion project to build its capacity to respond to physical health care needs. This commenced with a survey of staff tobacco use and of staff attitudes and beliefs about consumers' tobacco use. It was apparent that staff required further education and support to assist them to actively pursue non-smoking strategies with consumers. State-based Health Promotion Officers were employed to identify site champions and support the development of local level strategies. In NSW as with the other states, the second phase of the project involves raising awareness of the poor health outcomes experienced by many consumers. The Health Promotion Officer will develop a range of strategies to support consumers to engage with their GP and to participate in regular health checks.

The Guidelines, programs and other resources being developed through the MHDAO, PRA and NEAMI projects and initiatives will provide a proposed *Recovery & Wellbeing Locals* Project with a head start with the initiation of health promotion and health self care management programs.

#### **4. Relevant enabling programs for accessing psychological services and primary health care through Medicare**

Private health and mental health professionals accredited with Medicare to provide items under the Medical Benefits Scheme offer psychological, primary health care and other health care services. In the absence of bulk billing, the services of these private professionals are often inaccessible to people living with persistent mental illness and mental health problems. There are a number of Medicare-based schemes that have been introduced to enable greater access to primary health care and psychological services. These schemes and provisions include but are not restricted to:

- *Access to Allied Psychological Services (ATAPS), part of the Better; Outcomes in Mental Health Care (BOiMHC) funded via GP Networks*
- *Better Access to Mental Health Care;*
- *Chronic Disease Management ('Enhanced Primary Care') Program;*
- *Allied Health Group Services under Medicare for patients with type 2 diabetes;*
- *National Mental Health Nurse Initiative;*
- *Mental Health Services Rural and Remote Program;*
- *Multidisciplinary Case Conference;*
- *Domiciliary Medication Management Review;*
- *Nurse Practitioner rebates;*
- *Expanded opportunities for Comprehensive Care Packages.*

.An overview of each of these initiatives and potential relevance to the proposed Recovery and Wellbeing locals are now outlines inturn.

##### **4.1 Access to Allied Psychological Services (ATAPS)**

The ATAPS enables GPs under the *Better Outcomes in Mental Health Care (BOiMHC)* Program to refer consumers to allied health professionals who deliver focused psychological strategies. Allied health professionals have been defined to include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications.

Through ATAPS, service users are eligible for a maximum of 12 sessions per calendar year; six time-limited sessions with an option for a further six sessions following a mental health review by the referring GP. Sessions can be individual and/or group therapy sessions. The ATAPS provides patients with assistance for short-term intervention. If further sessions are required it may mean that a longer term program is necessary in view of the complexity of needs.

In addition, the referring practitioner may consider that in exceptional circumstances the person may require an additional six individual focused psychological strategies above those already provided (up to a maximum total of 18 individual services per service user per calendar year). Exceptional circumstances are defined as a significant change in the person's clinical condition or care circumstances which make it appropriate and necessary to increase the maximum number of services. It is up to the referring practitioner to determine that the person meets these requirements.

Through ATAPS, service users are also eligible for up to 12 separate group therapy services, within a calendar year, involving 6-10 people. These group services are separate from the individual services and do not count towards the 12 individual allied mental health services in a calendar year.

Service users are not to be referred for treatment through *Better Access* to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule (Better Access) Program and ATAPS at the same time. Treatment through both Better Access and ATAPS may occur within one calendar year, provided the total number of individual or group services provided under both programs does not exceed the maximum allowable in a calendar year.

Divisions of General Practice act as fund holders in this component of the BOiMHC program. The AGPN provides an on-line Network Directory on its website at <http://www.agpn.com.au/> which allows searches using maps or a search interface to obtain information on divisions of general practice.

The ATAPs has played a critical role in helping people access psychological services through Medicare in areas where there are few registered practitioners or in areas where there is little bulk-billing. In some areas Divisions of General Practice have complemented the ATAPs-based services through the services of salaried mental health professionals or with services provided on a contractual basis by health service providers including for example the Royal Flying Doctor Service.

The proposed Recovery & Wellbeing Locals will be able to draw on and link to the arrangements and partnerships established by Divisions of General Practice for utilising the benefits of the ATAP.

## **4.2 Better Access to Mental Health Care**

On 1 November 2006, the Australian Government introduced the Better Access to psychologists, psychiatrists and GPs through the Medicare Benefits Schedule (MBS) Program. Rebates are available for consultations with psychiatrists, clinical psychologists, psychologists, social workers and occupational therapists. To qualify for rebates under the Better Access program, a person with depression, anxiety or other mental disorder first needs to get a referral from a General Practitioner (GP), psychiatrist or pediatrician. Conditions covered under the scheme include:

- Depression;
- Anxiety;
- Panic disorder;
- Obsessive compulsive disorder;
- Post-traumatic stress disorder;

- Generalised anxiety disorders and phobias;
- Bipolar disorder;
- Drug-use disorders; and
- Alcohol-use disorders.

The GP assists the person to develop a plan for the treatment of the individual's particular mental health problems. The plan nominates the health professional/s to whom the person will be referred and the available rebates for those services. Similar to the ATAPs, in one calendar year, a person with depression or another mental health problem, who is eligible for the rebates, can receive up to 12 individual consultations and up to 12 group therapy sessions with a mental health professional under Medicare. Extension of sessions is also possible.

The referring GP is required to assess the person's progress after each block of six sessions with a psychologist, or other mental health professional, using the Mental Health Treatment Plan as a guide. Review is required of whether the person is receiving the right treatment or if other options need to be explored.

Psychological services available through Better Access include:

- *Psychological Therapy* – for example Psycho-education, Cognitive Behaviour Therapy (CBT, Behavioural and Interpersonal Therapy);
- *Focused Psychological Strategies* – for example relaxation and stress management strategies and skills training in problem solving, anger management, improving social skills, improving communication, better parenting etc.

These sessions can be conducted individually or in a group setting.

The proposed Recovery & Wellbeing Locals will develop partnerships with accredited mental health professions to establish bulk-billing arrangements for people with severe mental illness who would benefit from the psychological approaches now available but who may not be able to obtain these services for themselves or who may not feel comfortable accessing them in formal clinical settings.

### **4.3 Chronic Disease Management ('Enhanced Primary Care') Program**

A chronic medical condition is one that has been (or is likely to be) present for six months or longer. It includes conditions such as asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke. People have complex care needs if they need ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers. People may be eligible if their GP has provided the following MBS Chronic Disease Management services:

- A GP Management Plan; AND
- Team Care Arrangements.

Medicare rebate is available for a maximum of five (5) services per patient each calendar year. Allied health professionals included in this scheme include:

- Aboriginal Health Worker;
- Audiologist;
- Chiropractor;
- Diabetes Educator;
- Dietitian;
- Exercise Physiologist;
- Mental Health Worker;
- Occupational Therapist;
- Osteopath;

- Physiotherapist;
- Podiatrist;
- Psychologist;
- Speech Pathologist.

Many people with mental illness and mental health problems who have high levels of needs would benefit and qualify for this scheme in view of their frequently complex set of health care needs. Despite this many miss out because of limited access or difficulty in accessing a GP. The proposed *Recovery & Wellbeing Locals* will support service users to access this scheme by establishing arrangements for on-site sessions with GPs, other primary health professionals and allied health professionals.

#### **4.4 Allied Health Group Services under Medicare for patients with type 2 diabetes**

People with type 2 diabetes can receive Medicare rebates for group services provided by eligible diabetes educators, exercise physiologists and dietitians, on referral from a GP. The group services items provide another referral option for GPs in the management of patients with type 2 diabetes. The allied health professional will initially conduct an individual assessment to prepare the person for an appropriate group services program. If the person is assessed by an eligible allied health professional as suitable for group services, the patient may then receive up to eight (8) group services each calendar year. Allied health group services may be delivered by one type of allied health professional (eg 8 diabetes education services) or by a combination of providers (eg 3 diabetes education services, 3 dietician services, and 2 exercise physiology services). The combination of group services to be offered will be determined as part of the assessment by the allied health professional.

In some areas, different types of group services may be offered by allied health providers (eg courses targeting newly diagnosed patients, refresher courses or courses covering specific types of treatment and self management).

Given the high incidence of diabetes 2 among people with mental illness, by easing access to this scheme, the proposed *Recovery & Wellbeing Locals* will play a key role in improving health outcomes and quality of life for service users.

#### **4.5 National Mental Health Nurse Initiative (MHNIP)**

In 2010, the Australian Government announced an additional \$13.0 million would be allocated to the MNHIP nationally, to engage 136 extra mental health nurses under the program. This brings the total funding for the MHNIP to \$79.777million over six years (2006/07 – 2011/12). At the end of April 2010, a total of 42,696 patients had been treated since the program's inception. This program provides non-MBS incentive payments to eligible community based general practices, private psychiatry services and other appropriate organisations (such as Divisions of General Practice or Aboriginal Medical Services) who engage mental health nurses to coordinate treatment and care for people with serious mental illness and complex needs.

Responsibility for the MHNIP rests with the Australian Government Department of Health and Ageing, while funding for the program is administered through Medicare. MHNIP Guidelines outline how payments are made on a half-day, sessional basis and allow credentialed mental health nurses to work closely with the patient's psychiatrist or GP to facilitate the provision of coordinated clinical care and treatment for people with severe mental health disorders. A 25% loading applies to organisations operating in outer regional, remote and very remote areas, and one-off establishment grants are available. There is little or no charge to the client.

The Mental Health Nurse Incentive Program (MHNIP) provides mental health nurses who are 'credentialed' under the ACMHN's Credential for Practice Program with an opportunity to work in primary practice. An aim of the program is to provide mental health clients with a more integrated treatment plan, improved continuity of clinical care and increased access to other health care professionals.

Services can be provided in a range of settings such as in clinics or at a patient's home. Support provided under this program targets people with severe mental health disorders during periods of significant disability. A general practitioner or psychiatrist determines eligibility for the service on the basis of the following criteria:

- The client must have a diagnosed severe mental health disorder, and
- the disorder must cause significant disablement to social, personal and occupational functioning, and
- the client has had at least one episode of hospitalisation for their mental health disorder, or be at risk of future admissions, and
- requires continuing treatment over the next two years, and
- the general practitioner or psychiatrist is principally responsible for the client's clinical mental health care, and
- the client consents to treatment by the mental health nurse.

A Mental Health Treatment Plan must be prepared in collaboration with the mental health nurse, outlining the roles and responsibilities of both the treating doctor and the mental health nurse. The plan must be reviewed regularly by the GP or psychiatrist with input, where appropriate, from a clinical psychologist or other allied health professional.

Mental health nurses address both the mental health and physical needs of clients and undertake relevant record keeping and reporting which is directly related to the program, or their scope of practice as a mental health nurse.

The range of client-focused services mental health nurses provide under the MHNIP includes:

- periodic reviews of mental state,
- Information on physical healthcare to patients,
- medication management and monitoring,
- provision of health promotion information,
- undertaking home visits,
- integrated clinical services from GPs psychiatrists, and allied health workers e.g. psychologists, and
- improving patient links to other health professionals and clinical service providers.

There are a range of ways mental health nurses choose to work under the program (ranging from direct employment or shared employment, to working in private practice under self-funded arrangements) and a number of practice and funding models exist. Some examples include the following.

*Mackay* - The MHNIP is run by the Mackay Division of General Practice (MDGP) in a direct employment model. MDGP also provide a psychology service and other allied health services to the community. There are six full-time nurses employed through the program, with one based at Airlie Beach.

*Ballarat* - For the MHNIP, Ballarat and District Aboriginal Corporation has entered into a partnership agreement with Australian Mental Health Services (AMHS), a private company. Nursing staff are employed by AMHS, which also provides their clinical supervision and professional development. BADAC contributes office space, computers, transport, mobile phone and all on-site expenses. There are two mental health nurses at BADAC; one is employed full time in a clinical role, the second nurse

delivers a range of organisational development activities in addition to two days clinical work under the MHNIP.

*Geelong* - There are two separate MHNIPs that are delivered through the General Practice Association of Geelong (GPAG). The larger program is the result of a partnership between GPAG and Barwon Health, and is designed to build effective working relationships between mental health services and GPs, provide an earlier intervention and better access to mental health services, and prioritise acute services. This program uses a shared employment arrangement to place seven (6.8 FTE) mental health nurses from Barwon Health across 29 practices, and provide support to more than 100 GPs. Barwon Health makes a significant financial contribution to the arrangement, providing a clinical coordinator, underwriting employment costs of the nurses and providing ongoing supervision for the nurses.

*Ipswich* - The current MHNIP model has four part-time nurses employed by Ipswich Mental Health, but contracted to the MHNIP. Ipswich West Moreton Division of General Practice (IWMDGP) is the auspice for the program, and works in close partnership with GPs and the mental health service.

The mental health nurses employed under this scheme are working hard to establish partnerships and sound working relationships with community mental health organisations to enable their clients to access the psychosocial and recovery support services they require.

There are a number of sustainability issues faced by the program including availability of credentialed mental health nurses, existing funding guidelines and funding models and parity of employment conditions. Some have retained their employment with public mental health services whilst also working with the program. A possibility worth exploring by the MHCC is the establishment of shared employment arrangements between a community mental health organisation with an established presence in a particular area, an Area Mental Health Service, a Division of General Practice, an Aboriginal Medical Service or another appropriate organisation (e.g. private provider).

#### **4.6 Mental Health Services Rural and Remote Access Program**

The Mental Health Services Rural and Remote Access program complements the Better Access to Mental Health Care program. Organisations operating under the program in NSW include:

- Royal Flying Doctor Service of Australia - NSW section;
- NSW Outback Division of General Practice;
- New England Division of General Practice;
- Southern General Practice Network;
- Hunter Rural Division of General Practice;
- Dubbo Plains Division of General Practice; and
- NSW Outback Division of General Practice.

The program uses a flexible service model and funds organisations to provide allied health and nursing mental health services in rural and remote areas. The majority of organisations funded under this program are Divisions of General Practice, although other service types such as the Royal Flying Doctor Service of Australia and Aboriginal Medical Services have been included.

Again, the MHCC could usefully explore the possibility of partnerships being established between community mental health organisation and the above organisations.

#### **4.7 Multidisciplinary Case Conference**

The case conferencing MBS items are for GPs to organise and coordinate or to participate in, a meeting or discussion held to ensure that a person's multidisciplinary care needs are met through a planned and coordinated approach. Clients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual GP and at least two other health or care providers are eligible for a case conference service.

A 'chronic medical condition' is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke; many of which people with long standing mental illness are higher risk of developing

Examples of persons who may be included in a multidisciplinary care team are:

- allied health professionals
- home and community service providers
- care organisers such as education providers, "meals on wheels" providers, personal care workers and probation officers.

The patient's informal or family carer can be included as a formal member of the team, but does not count towards the minimum of three service providers. A case conference can occur face-to-face, by phone or by video conference, or through a combination of these. The minimum three care providers (including the GP) must be in communication with each other throughout the conference.

Recovery and wellbeing Locals could liaise with GPs about the need for case conferencing and could also be involved with their conduct.

#### **4.8 Domiciliary Medication Management Review**

The Domiciliary Medication Management Review (DMMR), also known as a Home Medicines Review (HMR), is an MBS item for patients living in the community setting. This may only be initiated by a patient's GP after assessing a person's need for the service. The goal of a DMMR is to maximise an individual benefit from a person's medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy. It may also involve other relevant members of the health care team, such as nurses in community practice or key support workers.

The DMMR process utilises the specific knowledge and expertise of each of the health care professionals involved. In collaboration with the GP, a pharmacist comprehensively reviews a person's medication regimen in a home visit. After discussion of the pharmacist's report and findings, the GP and patient agree on a medication management plan. The person is central to the development and implementation of this plan with their GP. Payment for the review under the MBS will not occur until after the second patient consultation.

Given the complex mix of medications frequently prescribed for people with mental illness and numerous physical health care needs, this is a further MBS item which could assist people receiving services *from the Recovery & Wellbeing Locals*.

#### **4.9 Nurse practitioner rebates**

Under changes, which came into effect recently on 1 November 2010, Medicare benefits will be payable for services provided by eligible privately practicing nurse practitioners working in collaboration with a medical practitioner. These items are time tiered and take into account the complexity of the patient's condition, enabling nurse practitioners to provide a broad range of services within their scope of practice. Participating nurse practitioners will also be able to request certain pathology and diagnostic imaging services for their patients and refer patients to specialists and consultant physicians, as the clinical need arises rebates will be payable for visits to a nurse practitioner, nurses who have been

trained to a higher level than registered nurses, who are already commonly employed in GP surgeries.

Rebates for nurse practitioners will vary according to the time of the consultation and complexity of the service. For a simple attendance of up to five minutes, the rebate will be \$9.20, while for a standard consultation of up to 20 minutes the patient will receive \$20.15 back from Medicare. Longer consultations, lasting from about 20 to about 40 minutes, will qualify for a rebate of \$38.25, while longer than 40 minutes will earn \$56.30.

Though the new rebates are small, they do afford new opportunities for nurse practitioners who are working in their private practice. It is possible that the new rebates may assist nurse practitioners to widen the settings in which they practice or conduct sessions to include community mental health organisation such as the proposed *Recovery & wellbeing Locals*.

These are just nine relevant Medicare-based schemes that could be accessed by clients of the proposed Recovery & Wellbeing Locals via partnerships with primary health services and practitioners. It is possible that further schemes and programs will be identified during the planning and initial phases of the proposed project.

#### **4.10 Expanded opportunities for Comprehensive Care Packages**

As discussed above a further relevant initiative for which Medicare Locals will assume responsibility is the expanded *Flexible Care Packages*. In the 2010-2011 Commonwealth Budget, the Australian Government provided \$58.5 million over four years to deliver new packages of coordinated care to better support up to 25,000 people with severe mental illness being managed in primary care, to be delivered through Access to Allied Psychological Services arrangements. Medicare Locals, once established, will be the fundholders for the care packages. The Recovery & Wellbeing Locals will provide a mechanism for the community-managed mental health sector to assist people with high needs to access these packages and for the sector to be involved with the implementation of these new packages

#### **4.11 Guidance emerging from the experience of community mental health organisations with these schemes**

The MHCC in its Autumn 2010 Newsletter, *View from the peak*, discusses examples of NGO experience in NSW with utilising the Better Access Scheme. The article also discussed lessons learned and emerging guidance from this experience.

*On Track Community Programs*, located on the NSW north coast, have been providing their clients access to an in-house psychology clinic from their Connections Centre since early 2007. The day centre doesn't identify itself as a clinical service but rather as a service providing psychosocial support and a range of rehabilitation services to people living with a mental illness in the community. They currently have a psychologist running a clinic once a week, seeing up to 6 clients a day for 50 minute sessions – many with 12 sessions to complete resulting in the psychologist being booked weeks in advance. Referrals to the clinic are only taken from individuals approved as On Track consumers due to issues related to OH&S safety and risk protocols. Individual risk audits are carried out for all consumer clients and renewed every 3 months as well as after discharge from an inpatient clinic.

For *Uniting Care Mental Health* (UCMH), who provide a range of counselling services at different sites around Sydney, setting up a clinical service and utilising MBS funding, was a natural progression in order to better meet the complex needs of their client base.

Headspace Mt Druitt, one of UnitingCare's youth focused services, provides a 'one-stopshop' where clients and visitors to the Centre can make an appointment to see an in-

house GP who can then refer them onto an in-house psychologist or social worker, without any cost to them. Referrals are also taken from external GP's and UCMH have taken the time to build good relationships with GPs through the Division of GPs. Setting up a clinical service at Headspace is providing a more complete youth friendly service, aimed at early intervention.

An example from interstate is *Companion House* in the ACT which provides integrated primary health services within a specialist torture and trauma service. The Medical Service has been identified on a number of recent occasions as a case study in exemplary practice for community-inclusive and multi-disciplinary primary health care. The Medical Service provides general practice and primary health services for refugees in their first 12 months in Australia. It is staffed by four part-time doctors who conduct sessions under various Medicare-based rebates and programs, an administrator and full-time, salaried practice nurse. More recently psychologists practising under the Better Access Scheme have also been engaged. The Medical Service is also used by asylum seekers and people from refugee backgrounds with complex needs.

The Companion House medical service is committed to longer GP consultations, bulk billing and interpreter use. The service includes facilitated referrals to dental, allied health, mental health and specialist health providers. Training placements are provided in Refugee Health for medical students and registrars.

People continue to use the Companion House Medical Service until the service finds a community GP to refer to in the person's local area. This process is becoming increasingly more difficult due to Canberra's shortage of GPs and of bulk billing GPs in particular. Increasingly Companion House has had to try and expand and stretch its medical services as it finds itself working as a parallel service, rather than a transitional service. Extra nursing and medical sessions will be required if this trend continues. The agency reports that there is an urgent need for specialised outreach services for young African, Burmese and Middle Eastern mothers to provide antenatal, postnatal and neonatal support.

### **Legal issues**

Any health and allied health practitioner, accredited under the Better Access scheme is eligible to access the MBS items, including psychologists, counsellors, social workers and occupational therapists. However, while many NGOs will have salaried employees with clinical experience, organisations receiving any kind of government funding cannot in any way be seen to be benefiting from the MBS – this is seen by Medicare as 'double-dipping' and is punishable by law. However, arrangements can be established with private health service providers or independent private practitioners to conduct sessions at the premises of a community mental health organisation.

According to the Australian Psychological Society (APS) the legally safest arrangement is for health or allied health practitioner to conduct clinical sessions under the auspices of the NGO. For example, a psychologist would pay the NGO a facilities fee, and not a percentage of the fee income. David Strokes, Manager Professional Practice, APS strongly recommends a clear separation between the service and the organisation.

*It is imperative to arrange a good firewall between the MBS supported psychology services and the organisation.*

### **Contractual issues**

There are a variety of ways that NGOs can engage independent contractors, and it is up to each organisation to be first clear on their own aims and requirements and find out what will work best for them. Karen Burns, Director of Uniting Care Mental Health explained the clinics at Headspace Mt Druitt are made up of a collaboration of public and private independent contractors (not employees) who are MBS certified. She commented that:

*UCMH engaged legal advice in the design of their contract to ensure industrial relations and Medicare requirements were addressed and the agreement was in line with what we are trying to achieve.*

By contrast, On Track Community Programs have an informal agreement, established without legal advice, with the psychologist to run the clinic at the Connections Centre. The clinical space is provided by the NGO without cost to the psychologist who handles all medical documents and referrals and chooses to bulk-bill clients. The psychologist works as a consultant who follows the processes established by On Track.

### **Lessons and guidance**

Contractual arrangements between an organisation and a contracted health professional / psychologist must be individually considered, negotiated and agreed upon between a NGO and the contractor. Issues might include the following.

- A facilities fee charged by the NGO to the health professional which could include any reasonable costs incurred by the organisation such as: cost of space, receptionist services, cleaning, etc
- An agreement that the health professional bulk-bills on consultations and covers the gap fee due to benefits of the contractual arrangement
- Regular and informal reports on the client from health professional to NGO
- Contractually agreed extras may include benefits to the NGO such as the health professional attending meetings, providing advice or giving recommendations on centre clients.

Salaried staff within the organisation can provide intake and assessment services – similar to an engagement triage. Administration and receptionist services can also be provided to support the workings of the clinic in the process of engaging the client and linking in with the GP.

### **Working with GPs**

The GP is always the first point of contact under the *Better Access initiative* and an appointment with them (through a specific Medicare item) is a prerequisite to referral. GPs are paid via MBS for coordinating management and the development of the Mental Health Care Plan (MHCP), which forms the basis for engaging with other health professionals. The GP is therefore the focus of primary care and ongoing reports must be provided by the referred health professional / psychologist, who will be aware of responsibilities for reporting requirements and obligations with regard to privacy. A contractual agreement may be made with the health professional to keep the NGO included in this reporting process.

At Headspace Mount Druitt, a GP has been contracted to work on-site and provides extended appointments to suit the needs of clients presenting with mental health problems and to develop the MHCP. He provides referrals to a wide range of services including to the other in-house contracted health professionals.

During the initial phase of the proposed project, these examples of community agencies facilitating access for clients to Medicare-based primary health and psychological services will be examined in more details. Further information gained will inform the development of a range of service models which could be used as starting points by partnerships engaged in the project.

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Other: Research from the UK Equal Treatment: closing the Gap Report and Investigation - All background research and investigations are available on the DRC website [www.drc-gb.org/healthinvestigation](http://www.drc-gb.org/healthinvestigation)