

# **Regional planning and the Implementation of Integrated Mental Health Care: the experience of Partners in Recovery**

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## Summary

- Improved care integration is a core element for improvement of Australia’s mental health services. This requires fundamentally better links between health-focused care and social and community-based supports.
- The fragmentation of Australia’s health systems – ranging from a public hospital system funded and managed at state level and primary care at federal has created a series of fissures that have proved hard to bridge.
- Policy-makers have supported an institutional shift to local and regional action to overcome these historic splits.
- Partners in Recovery was a briefly successful nationally funded, locally managed program that attempted to improve outcomes for people living with severe and chronic mental illness and achieve system change.

# Recovery

- A Goal of the WHO Mental Health Action Plan (2013-2020)
- From the same document: **“From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure.”**
- Focus is on the individual.
- Important is the creation of ‘recovery oriented services’ which promote recovery for individuals through any care that is provided.

# PIR target group

- Around 600,000 Australians experience severe mental ill-health.
- Of these, 60,000 have enduring and disabling symptoms with complex, multi-agency support needs.
- PIR focused on 24,000 people within this 60,000 group.
- These people experience persistent symptoms, significant functional impairment, and psychosocial disability.
- They are reported to often fall through the system gaps and require more intensive support.

# Partners in Recovery (PIR)

## Overall aim of PIR:

- To improve the system response to people with severe and persistent mental illness who have complex needs (the target group)
- To improve recovery outcomes for those people using the PIR services

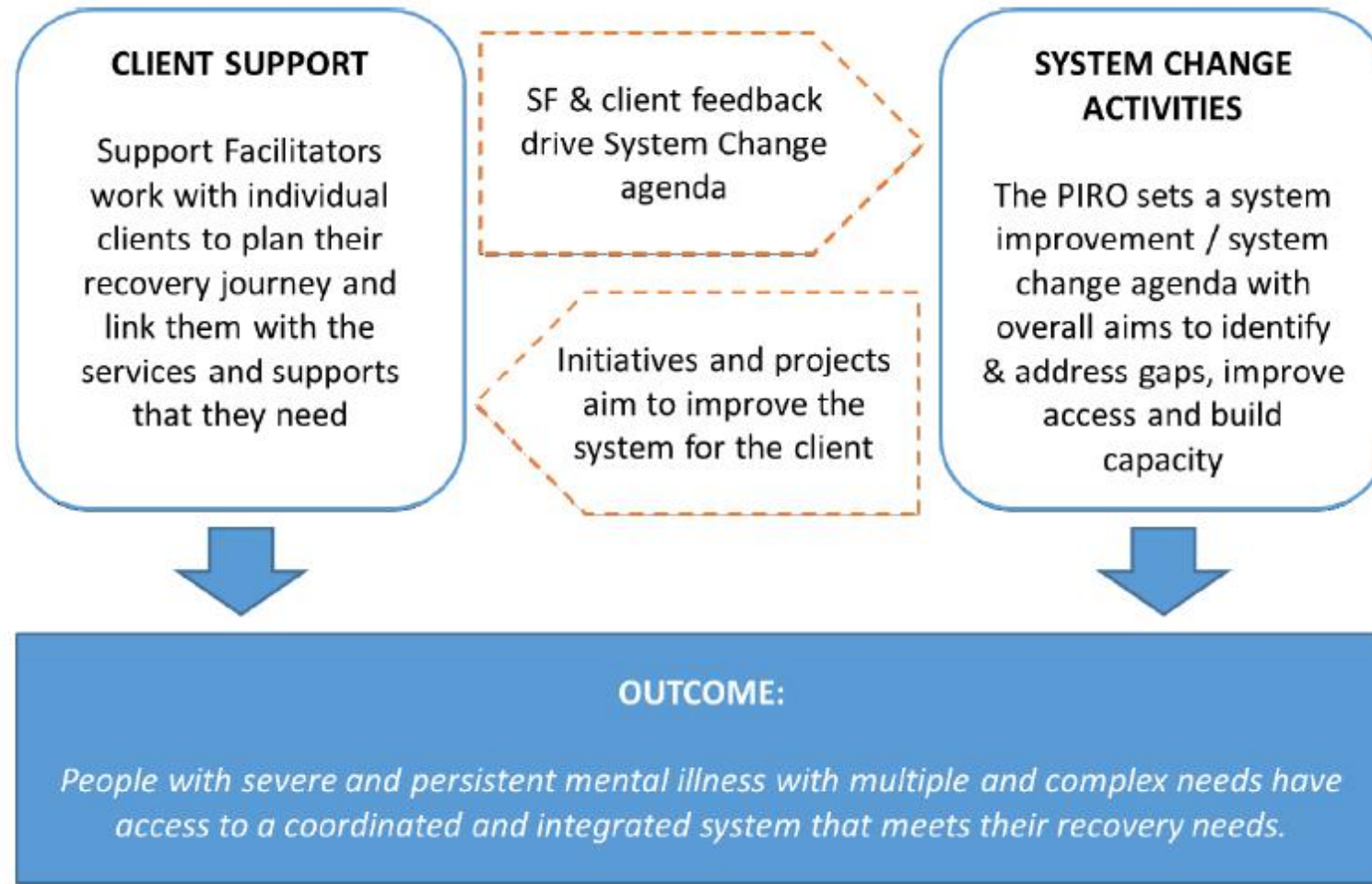
## Did this through:

- Prime contractor principal-agent model. Funding devolved to regional Hub organizations and service organization (NGOs with experience in mental health)
- Drawing together fragmented services to work in a more collaborative, coordinated, and integrated way.
  - Facilitating better coordination;
  - Strengthening partnerships between services and building better linkages;
  - Improving referral pathways; and
  - Promoting a community-based recovery model.

## Timeline: political cycles and institutional instability

- 2007-2013 Rudd-Gillard-Rudd Australian Labor Party governments
- 2011/12 Budget \$549.8 million for Partners in Recovery (2012/13 to 2015/16)
- 2013/14 PIR consortium bids in 49/61 Medicare Local regions
- 2013- Abbott-Turnbull-Morrison Coalition governments
- 2015 Medicare Locals abolished. Replaced by 31 Primary Health Networks
- 2016 National Disability Insurance Scheme
- 2016 PIR extended on an annual basis while participants moved into NDIS
- 2019 PIR ended

# The PIR model



## Client support: Support Facilitation

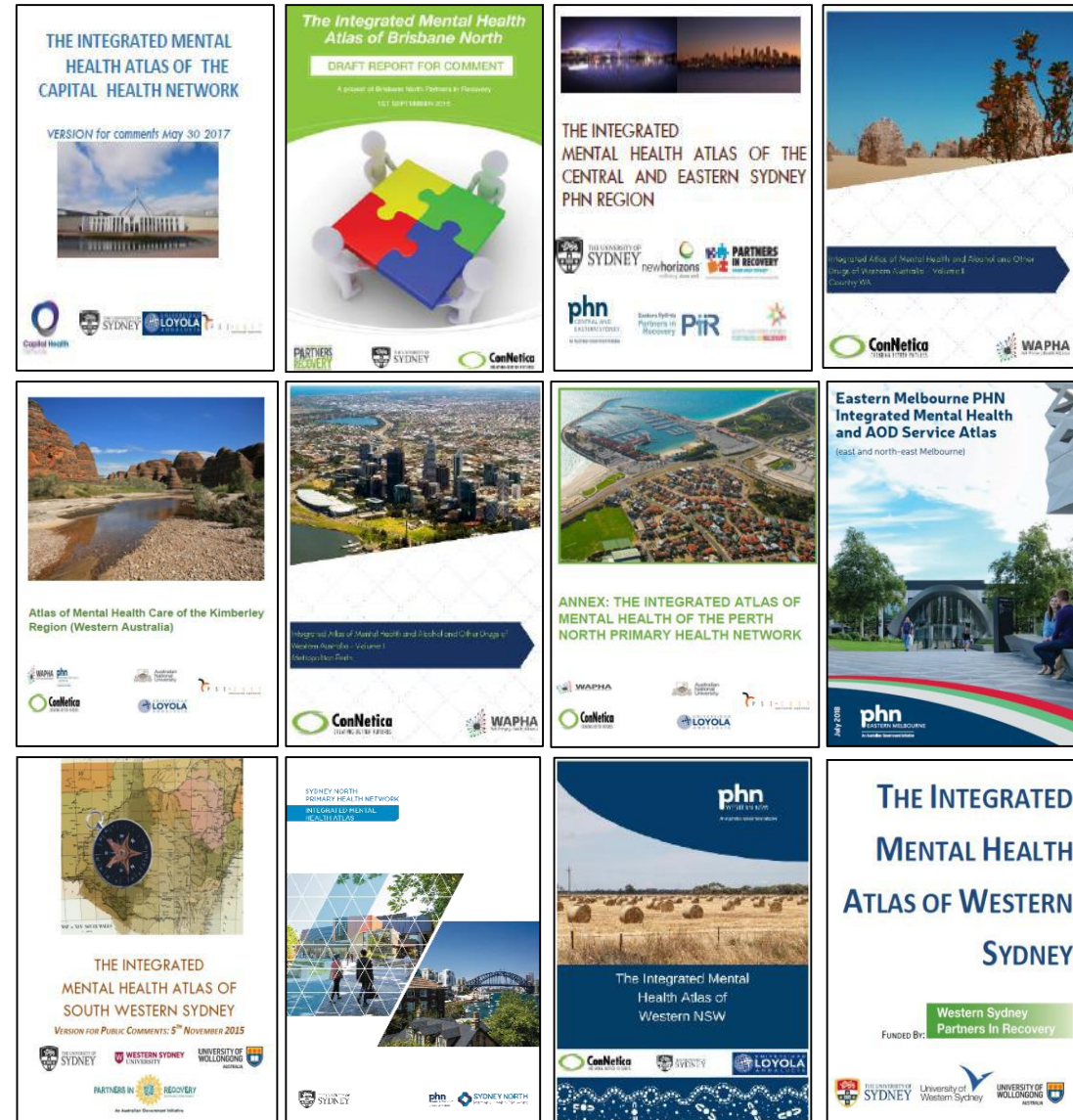
- The Support Facilitator
  - Deliberately expressed as distinct from case management (Smith-Merry et al, 2015).
  - PIR operational guidelines SFs must “ensure their support facilitation/coordination focus is maintained and not shifted to a case management focus”.
- The role of the SF was not to ‘manage’ the consumer (the ‘case’) but to manage the system.
- Job descriptions: “in the main, be a coordinator of the service system, not a ‘service deliverer’ in the traditional sense; in working to improve the system response to a [PIR] client, engage with and chase up services and supports, build service pathways and networks of services and supports needed” (Stepping Up, 2015)



# Integrated Mental Health Atlases

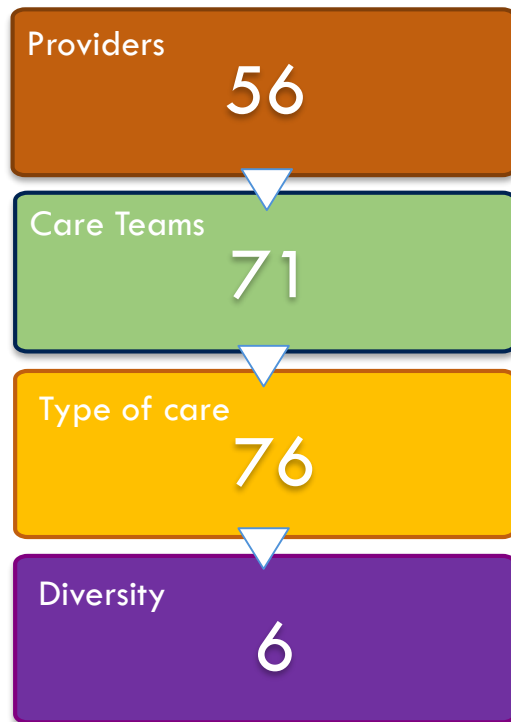
Results come from 11 PHN regions studied in 13 Integrated Mental Health Atlases:

- Australian Capital Territory
- Brisbane North
- Central Eastern Sydney
- Country Western Australia
- Perth North
- Perth South
- South Eastern Melbourne
- South Western Sydney
- Sydney North
- Western New South Wales
- Western Sydney (two versions)



## Description of the mental health care provided by PIR teams

Summary PIR teams in the Atlases:



Under the same name, PIR teams delivered different care.

**61 organisations** provided the **71 PIR teams** identified in the 11 PHN regions.

The **PIR teams** were described with **76 codes of DESDE-LTC system** for the standard description of long-term care services (Salvador-Carulla et al, 2013), i.e. some teams delivered more than one type of care (e.g. accessibility and information).

**PIR teams** were described by using 6 different codes within 3 large care typologies of DESDE-LTC system:

**A - Accessibility to care:** access to care without direct provision of care related to needs (e.g. access to employment)

- A4 – Case coordination

**O - Outpatient care:** contact with the person in a limited period of time (e.g. visit with the GP).

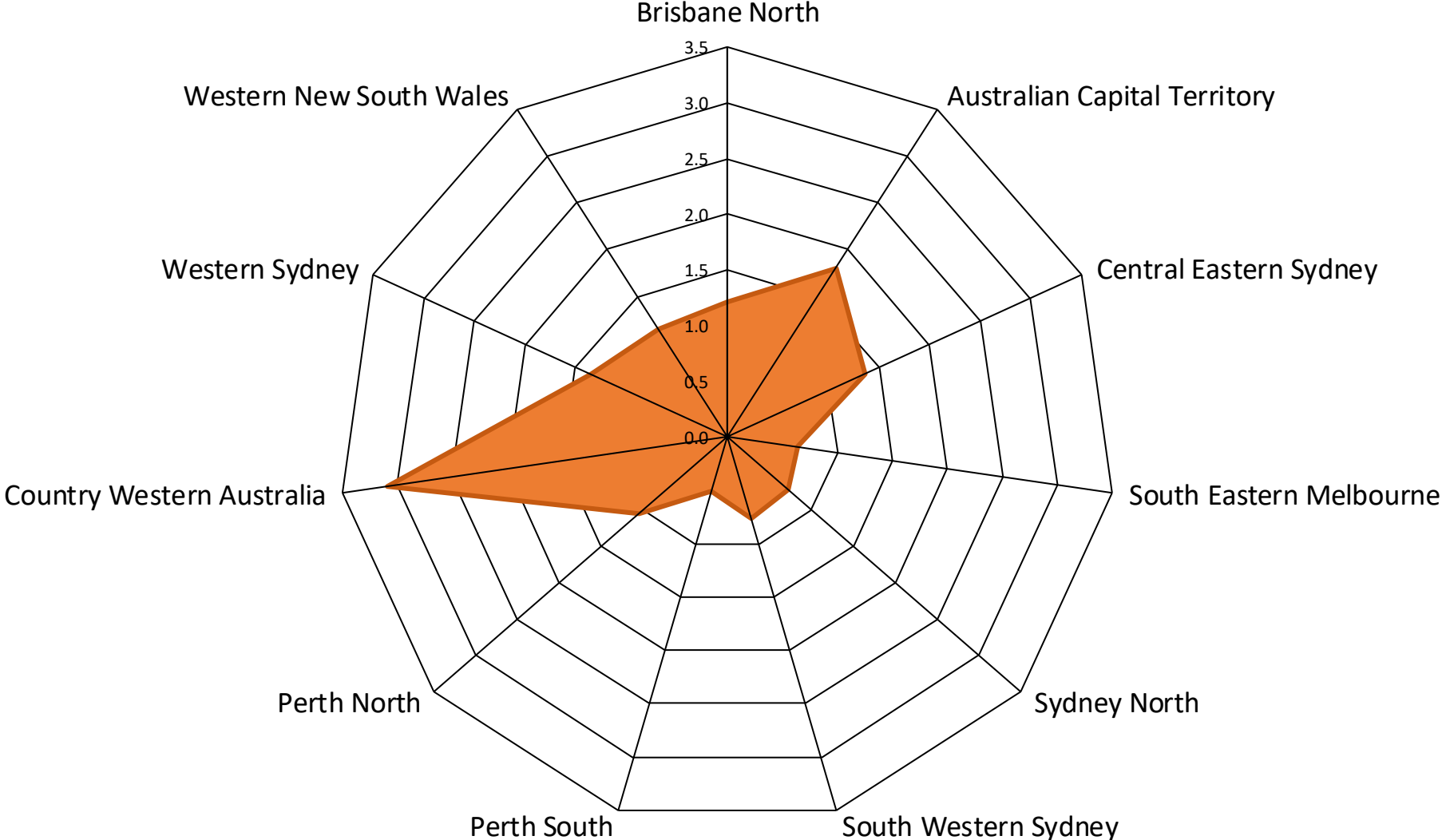
- O5.1 - Non-acute mobile health-related care, frequency of at least three times per week.
- O5.2 - Non-acute mobile other care, frequency of available at least three times per week.
- O6.2 - Non-acute mobile other care, frequency of available at least once a fortnight.
- O9.2 - Non-acute non-mobile other care, lower frequency than once a fortnight.

**I – Guidance and Information for care:** guidance/ assessment/ information WITHOUT follow up (e.g. information about availability of services)

- I1.1 – Health-related guidance.

# Availability of PIR teams

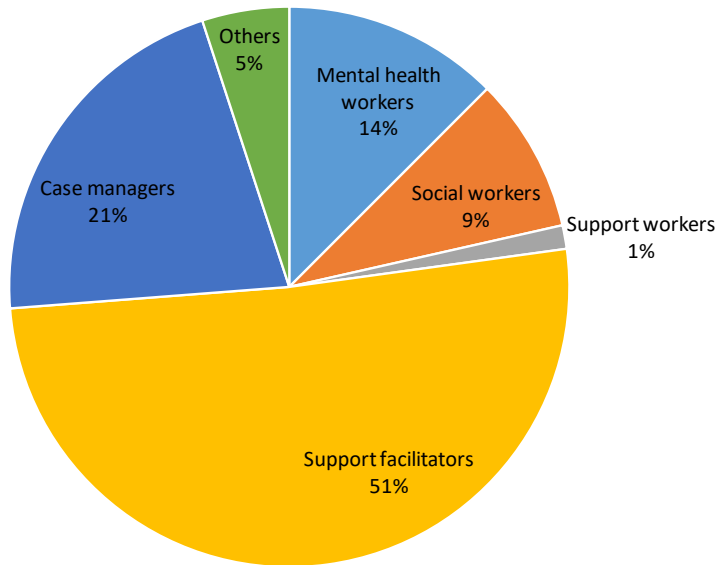
Rate of PIR teams per 100,000 inhabitant (>18 y.o.)



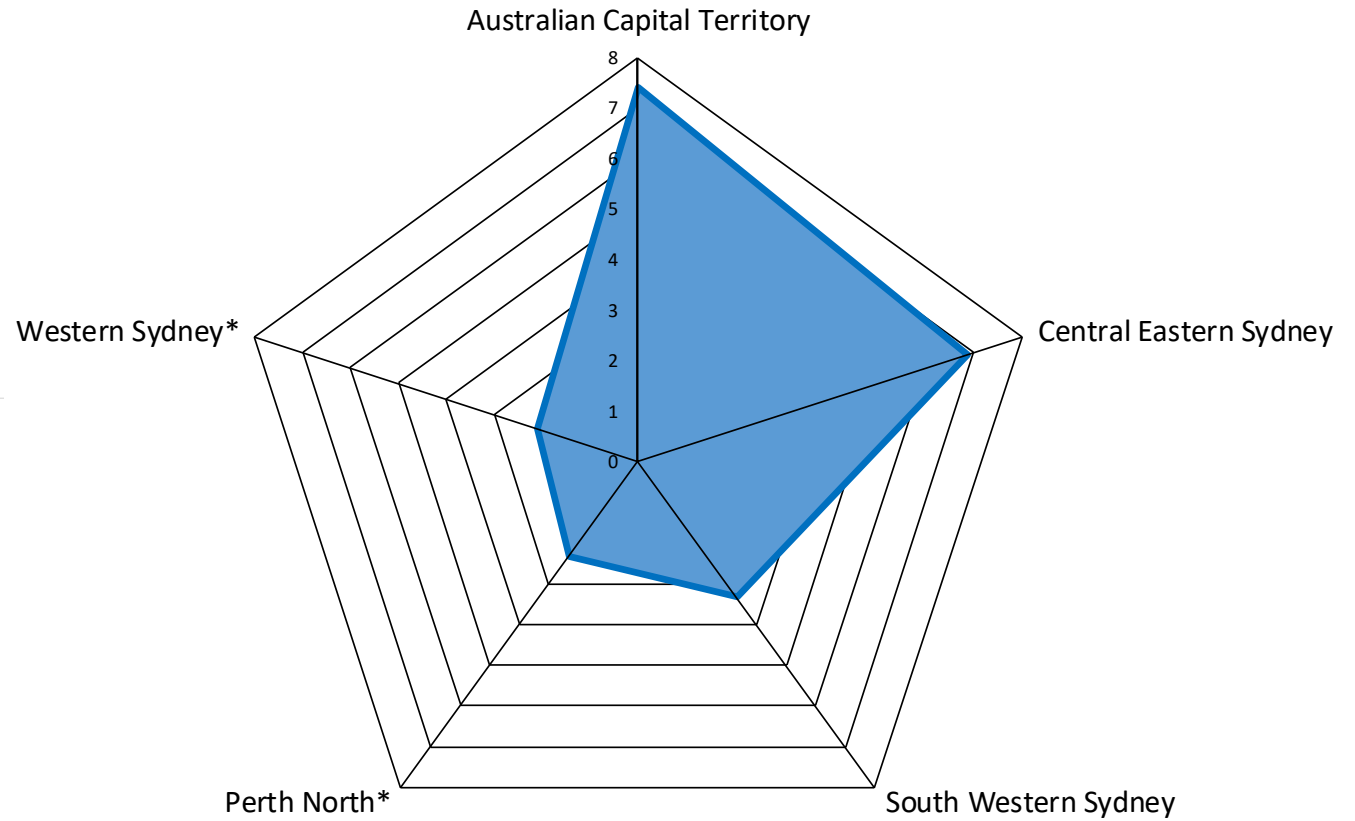
# Workforce capacity of PIR teams

There is information on professionals for 5 PHN regions (In 2 PHNs a few PIR teams did not report workforce composition)

**Professionals in PIR**  
 Australian Capital Territory, Central Eastern Sydney, South Western Sydney, Perth North and Wester Sydney



**PIR teams staff rate per 100,000 inhabitants (>18 y.o.)**

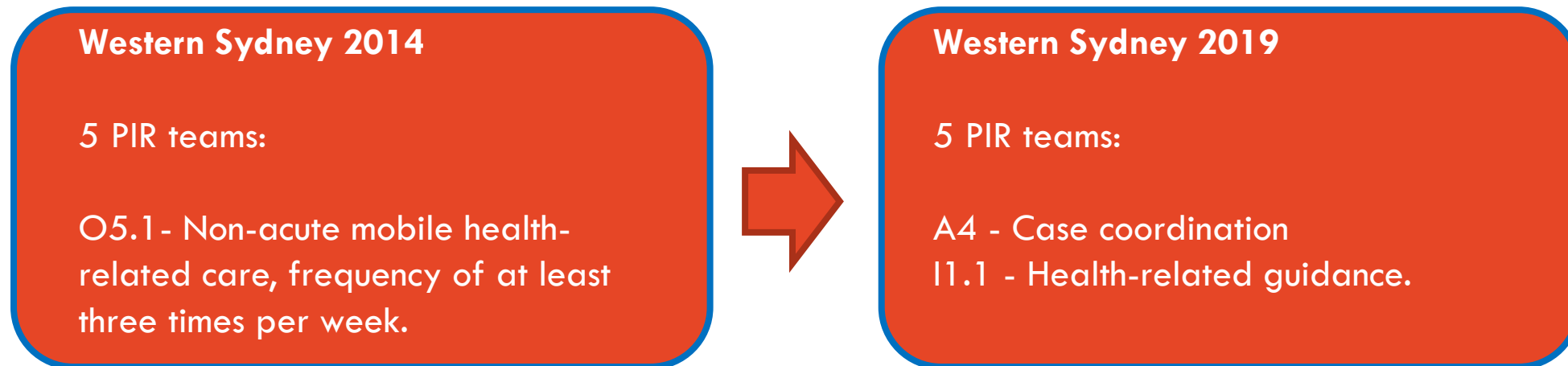


\* Incomplete data

## Evolution of PIR teams in Western Sydney (2014/2019)

Context adapted system

PIR teams were described as outpatient services in the Atlas 2014. However, they have been recoded as Accessibility services in the new Atlas 2019. Their previous coding was due to the additional support they had been required to provide at that time. These have now been recoded as Accessibility, the type of care for which they were primarily intended. In this last Atlas, PIR teams have also been provided with an additional Guidance and Assessment code, as they are now supporting clients with assessments for NDIS applications.

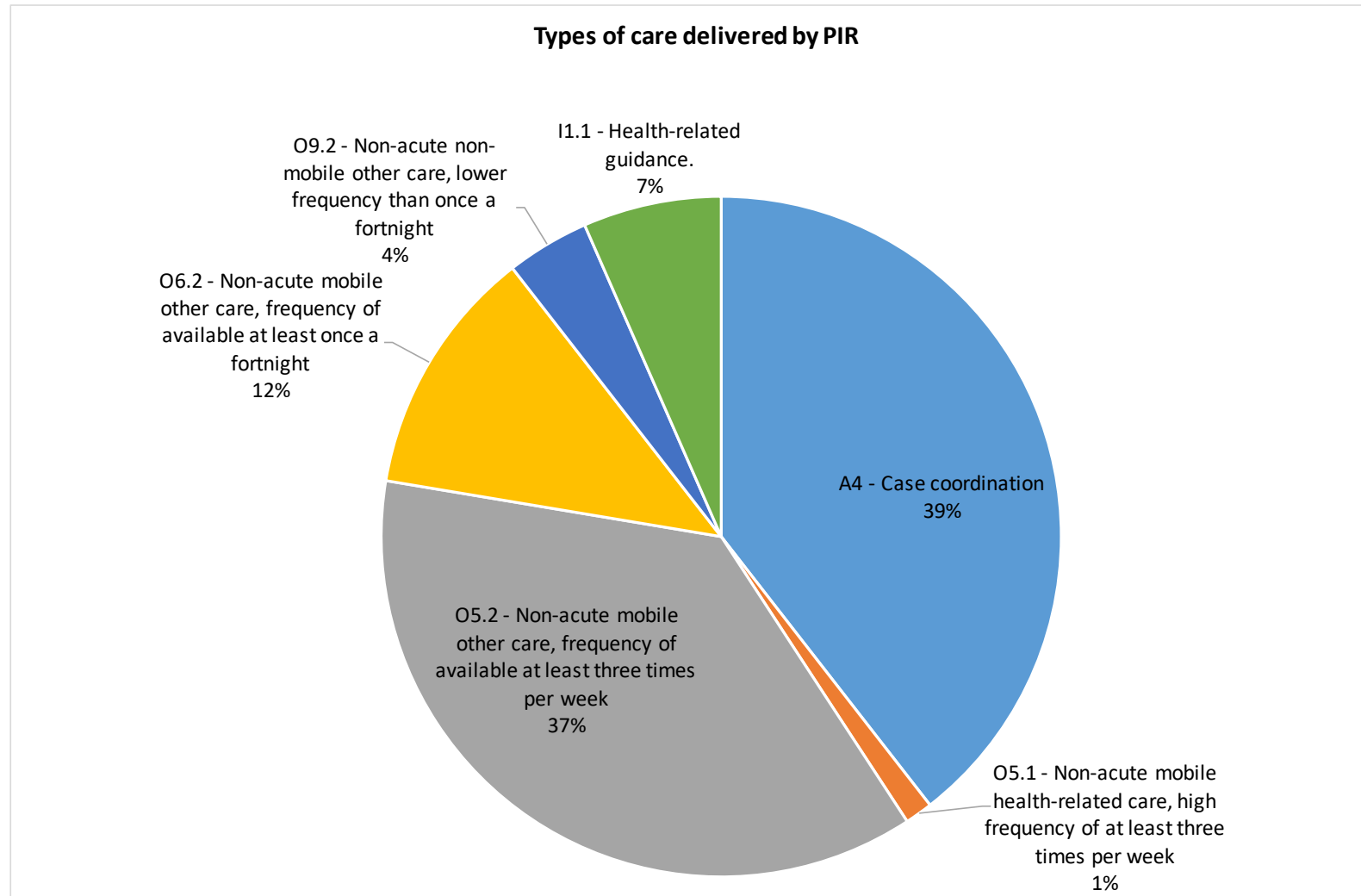


In five years they have changed the type of care delivered

## Count of providers and DESDE-LTC codes per PHN

	Brisbane North	Australian Capital Territory	Central Eastern Sydney	South Eastern Melbourne	Sydney North	South Western Sydney	Perth South	Perth North	Country Western Australia	Western Sydney	Western New South Wales	TOTAL
Providers	8	5	9	4	4	4	3	7	5	5	2	61
A4 - Case coordination		4	5	7	1		1		5	5	2	30
O5.1 - Non-acute mobile health-related care, high frequency of at least three times per week							1					1
O5.2 - Non-acute mobile other care, frequency of available at least three times per week	8		10			5		4	1			28
O6.2 - Non-acute mobile other care, frequency of available at least once a fortnight		1			3		1	2	2			9
O9.2 - Non-acute non-mobile other care, lower frequency than once a fortnight								1	2			3
I1.1 - Health-related guidance.										5		5
TOTAL codes	8	5	15	7	4	5	3	7	10	10	2	76

## Types of care delivered by PIR in 11 PHNs



## What happened to support facilitation?

- Evaluations generally found positive outcomes (CANVAS, RAS-DS)
- SF key to success: position poorly defined, enabled it to work across established boundaries. This lack of definition at the same time was a barrier to institutionalising practice.
- Central problems: lack of funding continuity, institutional instability (abolition of Medicare locals and replacement with Primary Health Networks 2015/16).
- National Disability insurance Scheme
  - Based on criteria of ‘permanent’ disability, rather than recovery.
  - PIR agencies shifted to case management – to move clients into NDIS.



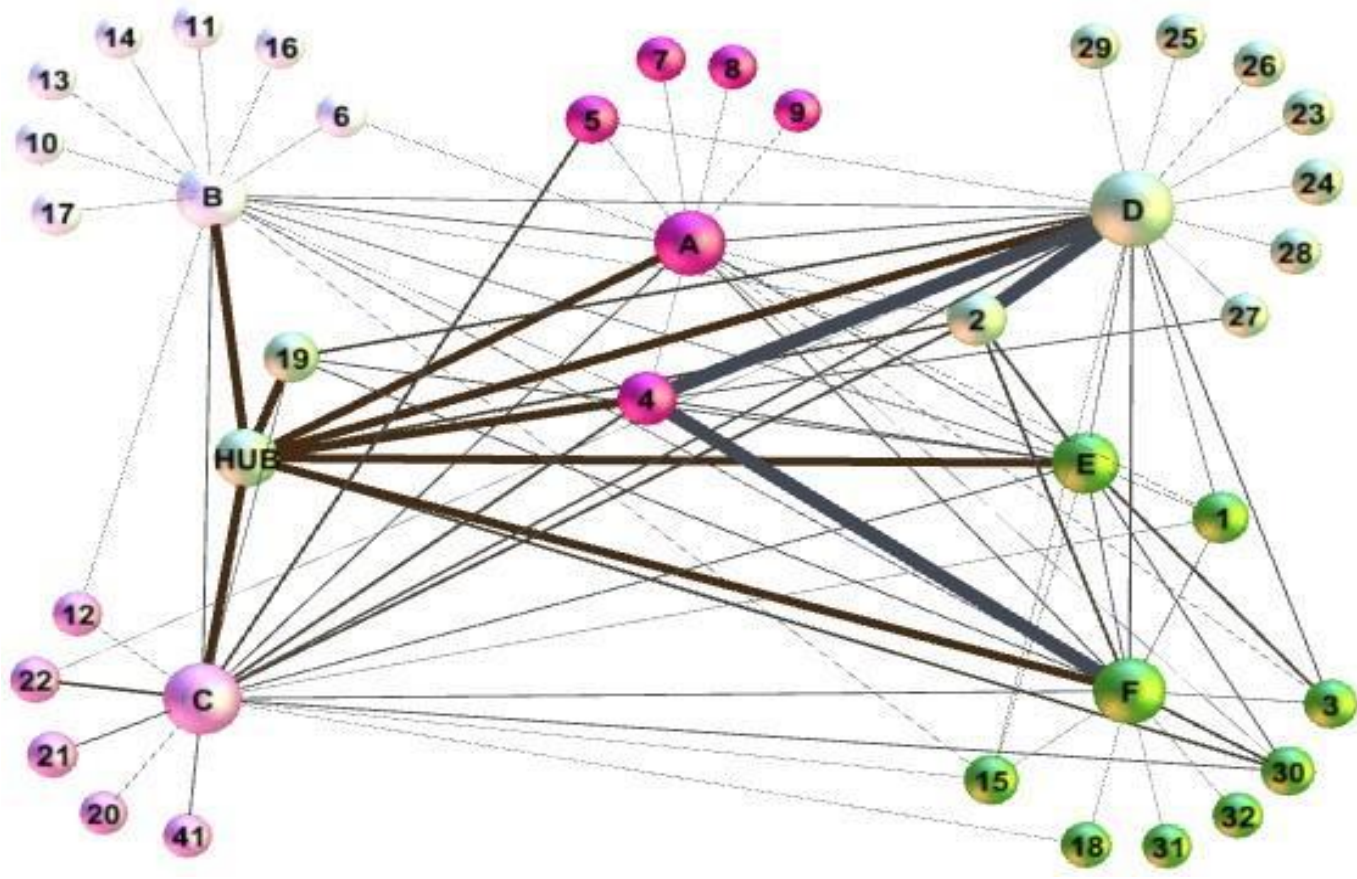
# Social network analysis: fragile devolved connections

Devolved control without systems change.

- Lasting service connections not developed effectively
- Remained focused on the lead agency, relying on Support Facilitators to build local partnerships
- Lack of supporting infrastructure : little system preparation or workforce planning' (Banfield et al 2018; Smith-Merry, Gillespie, Hancock and Yen 2017).

# PIR Network, Western Sydney

Connectivity mapping at macro-level: Partner-organizations network structure in the mental health system of Western Sydney. Care partner-organizations (A, B, C, D, E, F, and HUB) are connected to services nodes (labeled with numbers)



Key: HUB = PHN; A-F = service organizations (NGOs); 1 = Education services; 2 = Dept of Housing; 4 = community health; (M.Rabiul Hasan, Univ of Sydney)

## Conclusions: Governance and Commitment

- Lasting institutional changes were difficult due to the instability of the program and its final attempted integration into the very different National Disability Insurance Scheme.
- Implementation studies need to understand systems and governance context
  - Political environment: commitment beyond the political cycle
  - Other competing programs
- Care integration requires long-time frames to get sustainable commitment
  - PIR: truncated national evaluation
  - Poorly planned program closure

## NOTES ON ATLAS CODING OF PIR

The main objective of the PIR program is to increase the accessibility to a different range of services for people with a lived experience of mental illness

Interestingly, though, these providers are not just focused on accessibility, but take a more holistic approach, providing also some counselling.

Theoretically, the code of the PIR program should be an A4 (accessibility/care manager), but some organisations in other regions report that they are providing more intensive direct day care, so they received an outpatient code (O5.2). They can meet according to the needs of the consumer, with the capacity of meeting them on a daily basis if needed in the first stage of the program.

Studies on the effectiveness of PIR in this region show that despite issues with program stability caused by changing government priorities (Smith-Merry, Gillespie, Hancock, & Yen, 2015), this service has assisted in reducing the level of unmet need and promoting recovery (Hancock, Scanlan, Gillespie, Smith-Merry, & Yen, 2018).

Our coding of PIR, which in 2014 reflected the extension of its role in the region to include outpatient care as needed, is in this atlas reflective of its additional assessment capacity to assist people with the transition to the NDIS. This capacity to respond to changing community need is a demonstration of self-adaptation within the system as outlined in the introduction to this discussion: that is, while the service may have deviated to some extent from its ascribed core function, it has been able to identify and effectively respond to changing need in its environment.