Eastern Mental Health Service Coordination Alliance

EMHSCA Strategic Direction and Work Plan

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EMHSCA Project Officer

2019-2021

Creating opportunities to work strategically across the region with multi-sectoral partners

EMHSCA Work plan 2019-2021

Contents

Eastern Mental Health Service Coordination Alliance (EMHSCA)

The following is a list of the organisations and partnerships involved in this alliance. Most members are signatories to the EMHSCA MOU.

- Anglicare Victoria
- Australian Government Department of Human Services
- Bolton Clarke
- Campbell Page
- Connect 4 Health (Inner East Community Health Services)
- Delmont Private Hospital
- Department of Health & Human Services – Inner and Outer Eastern Melbourne
- Dual Diagnosis Consumer and Carer Advisory Council & Working Group
- EACH
- Eastern Community Legal Centre
- Eastern Health Mental Health Services – Adult, Aged Consumers, Child and Youth
- Eastern Health Turning Point
- Eastern Homelessness Service System Alliance
- Eastern Melbourne PHN
- EMR Regional Family Violence Partnership
- **EMR Dual Diagnosis Response**
- Independent Mental Health Advocacy
- Inner East Primary Care Partnership
- Job Co.
- Knox City Council
- Latrobe Community Health Service
- Maroondah City Council
- Mentis Assist
- MIND Australia
- Mullum Mullum Indigenous Gathering Place
- NDIA – Eastern branches
- NEAMI National
- NEXTT
- Outer East Health and Community Service Alliance
- Salvocare Eastern
- Wellways
- Whitehorse City Council
- Uniting Prahran

Background

In 2009 the inner- and outer- eastern Mental Health alliance groups joined to form the Eastern Mental Health Alliance which aimed to support the delivery of more accessible, appropriate and coordinated mental health services to improve the experiences of mental health consumers, carers and practitioners. The Alliance has expanded to include a wide range of regional partners to support a broader focus on mental health service coordination and integration across the service system. This Alliance has been called the Eastern Mental Health Service Coordination Alliance (EMHSCA) since 2012 in order to reflect the inclusion of the broader membership, and exists across Inner- and Outer-Eastern Melbourne. The range of sectors includes Mental Health, Alcohol & Other Drugs (AOD), Homelessness & Housing, Family Services, Family Violence specialist services, Aboriginal services, Primary and Community health services, Employment supports, NDIS providers, Local Area Coordinators, Centrelink, Consumer advocacy and Community Legal services, and is supported by the Department of Health and Human Services (DHHS).

Originally funded by DHHS, EMHSCA has been funded in partnership by various members since 2012. For the period 2018 to 2021 EMHSCA is co-funded by DHHS, the Eastern Melbourne PHN and Eastern Health. Member organisations provide their time and resources in-kind to the functioning of EMHSCA.

With respect to the common agenda for partners, the focus of EMHSCA has been the implementation of improved systems and processes to support service coordination and integration for the benefit of people with mental ill-health and other co-occurring concerns. Alliance members have introduced these improvements to their organisations following a process of collaboration. The local Dual Diagnosis initiative has been aligned with the work of EMHSCA since its inception, and continue to have a collaborative relationship. This has provided the Alliance with a significant Mental Health and Alcohol and Other Drug (AOD) focussed peer advisory function, along with organised grass roots staff linkages.

EMHSCA initiatives have included the following: the EMHSCA MOU (25 signatories); Service Coordination focussed workforce development activities (36 events provided for 3,194 staff 2010- June 2018); EMHSCA Shared Care Audit (6940 files across 6 orgs. over 4 years) and consumer survey; EMHSCA Shared Care Protocol; Eastern Peer Support Network; EMHSCA service mapping; EMHSCA Colocation guide; EMHSCA Shared care plan guide; and a range of EMHSCA tip sheets. The EMHSCA shared repository can be located here https://www.easternhealth.org.au/services/mental-health-services/eastern-mental-health-service-coordination-alliance.

Our Vision

For people who experience mental ill-health and co-occurring concerns, and the people who support them, to access responsive, appropriate and collaborative services to assist with the multiple facets of their individual recovery journey.

Our Values

As EMHSCA we value:

A Strategic approach by encouraging the expansion of organisational thinking and planning into a broader regional context.

A Respectful approach by treating everyone with courtesy and fairness, acknowledging all viewpoints, respecting diversity, and ensuring constructive honesty.

This Alliance sees participation from a diverse network of services, consumers and carers who commit to being actively involved in the sharing of information, practice wisdom, resources, and innovation.

Working collaboratively to support each other to achieve common goals and enhance integrated practice across the region.

Capacity building to assist with continuous improvement of the services provided in this region, enhancing collaboration and coordinated care.

EMHSCA Aim

To strengthen Mental Health and AOD service collaboration, coordination and system integration across Inner and Outer Eastern Melbourne for improved consumer outcomes.

EMHSCA Priority Areas

1. Mental health and AOD service and system reform
2. NDIS

EMHSCA Function

EMHSCA is the key local Mental Health and AOD platform for health and community service consultation and coordination of service provision across Inner- and Outer- Eastern Melbourne.

EMHSCA Structure

The EMHSCA structure has undergone several revisions over time and in order to better meet the needs of its partners as they adjusted to system reforms. The following structure has been operating since June 2018 and was developed in response to the introduction of the NDIS. This simple structure is described below (see Figure a and Table 1).

Figure a EMHSCA Structure

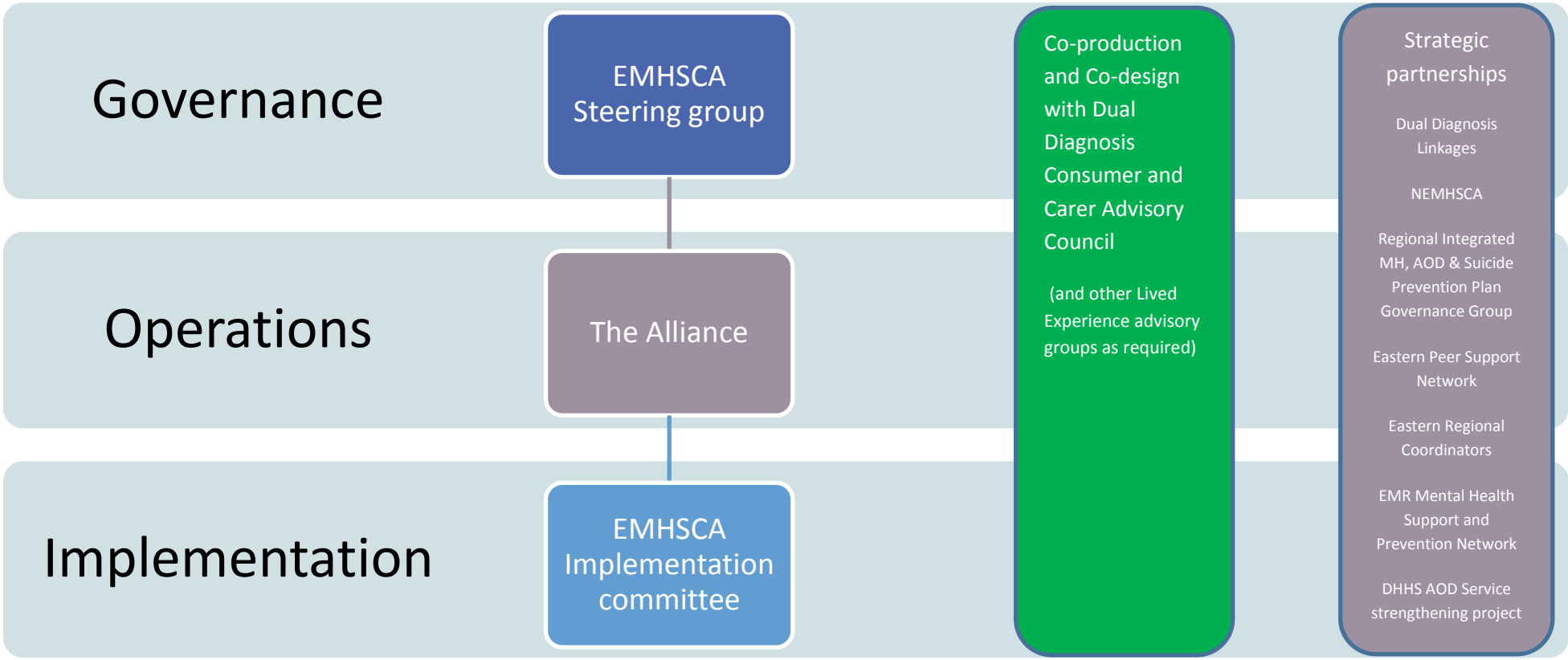


Table 1 EMHSCA Structure and function

Structure	Function	Membership	Funding
EMHSCA Steering Group	Governance	Primary Funding Organisations Executive Leadership, EMHSCA Co-Chairs, EMHSCA Project Officer	EMPHN and DHHS Eastern Health
EMHSCA "The Alliance"	Operations	MOU Membership Organisations' Senior Operational Leadership, DDCCAC consumer and carer representatives, EPSN coordinator, EMHSCA Project Officer	Funded Project Officer: DHHS, EMPHN, Eastern Health
EMHSCA Implementation Committee	Implementation of EMHSCA activities	Nominated representatives from MOU Member Organisations, DDCCAC chair, EMHSCA Project Officer	Funded Project Officer: DHHS, EMPHN, Eastern Health

EMHSCA Steering Group: functions to guide the direction of EMHSCA by making decisions regarding the scope and priority areas of work of the Alliance.

EMHSCA ("the Alliance"): functions to 1. Provide a platform for consultation and information sharing for various projects and initiatives; 2. Provide operational leadership and decision making in relation to the work; 3. Improve collaborative practices across sectors; 4. Provide a key communication mechanism for EMHSCA partners.

EMHSCA Implementation Committee: functions to 1. Implement the implement the initiatives from the EMHSCA work plan; 2. Enhance capacity of partner services in relation to key initiatives.

EMHSCA strategic partnerships

EMHSCA will maintain a strong relationship with the EMR Dual Diagnosis response comprising the Dual Diagnosis Consumer and Carer Advisory Council (DDCCAC); Dual Diagnosis Working Group (DDWG); Dual Diagnosis Linkages. This will ensure that Dual Diagnosis, the top shared priority of EMHSCA partners, continues to be addressed, and consumer and carer leadership is across all aspects of the work. Coproduction in designing projects for consideration by EMHSCA is essential, and the DDCCAC will remain a member of EMHSCA. The Dual Diagnosis Working Group continues to work in-tandem with the DDCCAC to support the Eastern Metro Region Dual Diagnosis response. This collaborative relationship will provide support for the operational work of EMHSCA and the various projects.

The Regional Integrated Mental Health AOD and Suicide Prevention Plan and the DHHS AOD Service Strengthening Project will influence the work of EMHSCA. This work is in development and the role of EMHSCA in this work will be clarified over time.

The Eastern Peer Support Network (EPSN) was established by EMHSCA in 2015 and continues to provide support and networking for the EMHSCA partners peer-workforce. The EPSN coordinator is a member of the Alliance.

EMHSCA will establish and strengthen its' relationships with other regional mental health alliances such as the North Eastern Mental Health Service Coordination Alliance (NEMHSCA) and share ideas and opportunities across the regions.

EMHSCA embraces diversity

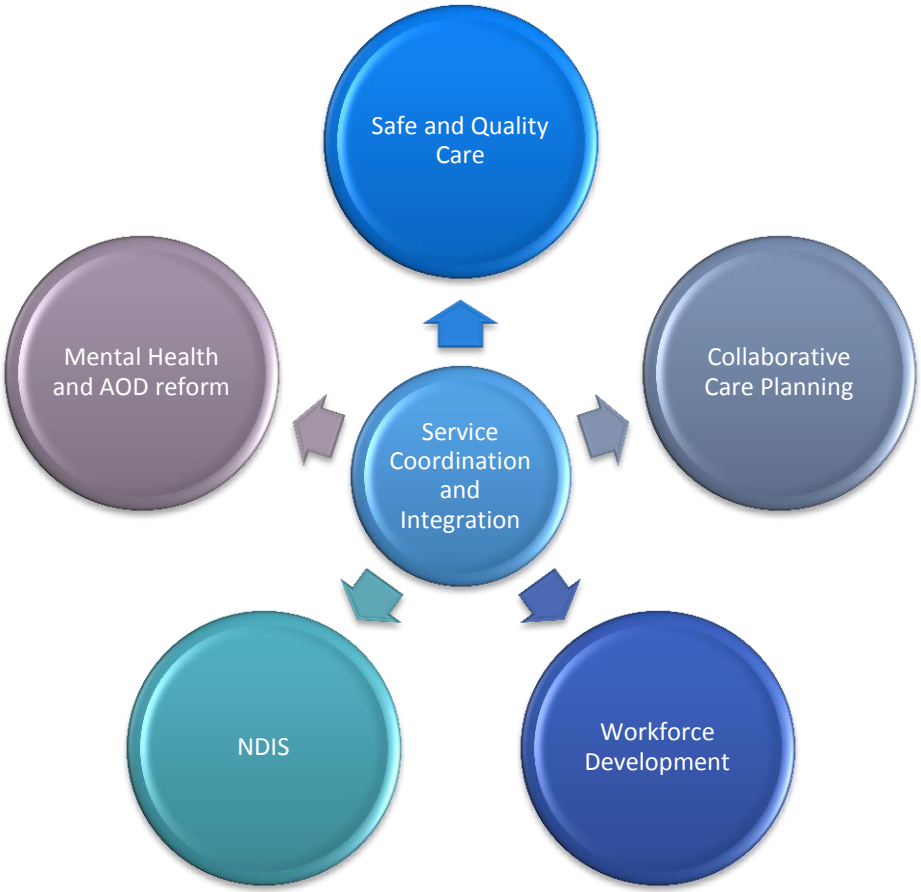
We welcome and celebrate diversity at EMHSCA, as we reflect the variety of cultures and communities we serve. Our Alliance strives for true collaborative practice and a spirit of inclusivity for all. EMHSCA recognises that poorer health outcomes are associated with experiences of discrimination and marginalisation. We challenge inequities in the development and delivery of health and community services.


EMHSCA acknowledges the traditional Aboriginal custodians of country throughout Victoria and respects them, their culture and their Elders past, present and future. EMHSCA recognises the ongoing impacts of colonisation on Indigenous Australians and the significant gaps in health care and equity for these peoples. EMHSCA is committed to gaining expert advice via engagement with local Community.

Co-design

EMHSCA endorses the Charter of Peer Support provided by the Centre of Excellence in Peer Support. EMHSCA aims to engage in co-design with the DDCCAC and other consumer and carer groups as required. By definition, co-design requires that EMHSCA work with service users for all service coordination quality improvement activities and events. This is facilitated by the representation of the DDCCAC on EMHSCA committees and also occurs via EMHSCA representation at DDCCAC meetings. Co-production is ideal and occurs when the DDCCAC (or other consumer and carer advisory groups) decide on an improvement project and ask EMHSCA to become involved. Broader consumer and carer consultation takes place with local service users additional to the leadership provided by the DDCCAC.

Figure b Strategic Priorities



EMHSCA Work Plan 2019-2021

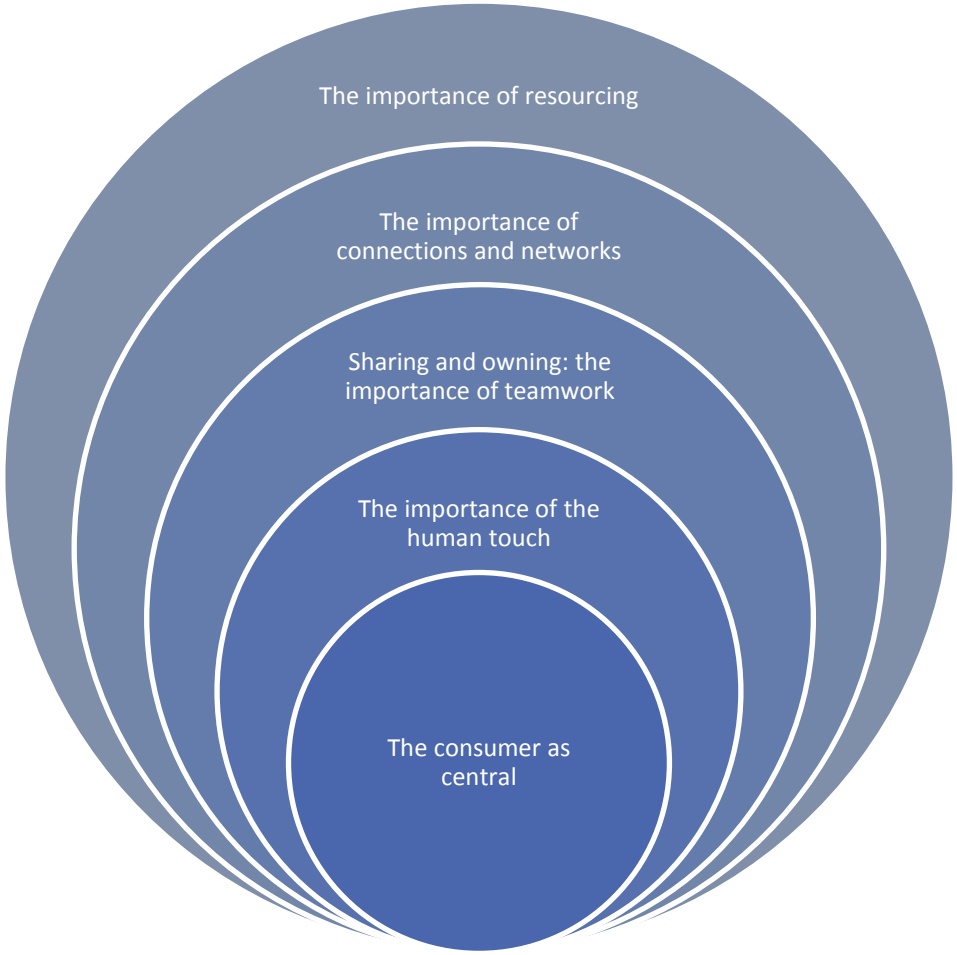
Key Priority Area	Key Outcome	Deliverables
1. Mental Health & AOD System Reform To improve consumer and carer access to person centred, timely, appropriate and integrated supports.	**Service system** Shared understanding of key issues and agreed application of service coordination and care pathways between partner agencies. **Organisation** Improved knowledge of local partners and shared issues, targeted capacity building, and improved intra-service communication mechanisms and pathways to support. **Practice** Improved workforce capacity to deliver appropriate services in partnership with consumers and carers, and other service providers.	1.1 For EMHSCA members to identify and manage local issues and themes occurring in the sector: i. Provide a forum in Alliance meetings to identify local themes and raise issues for discussion and action as required. ii. Project Officer to collate issues/themes in meeting minutes. EMHSCA Steering Group to consider distribution of issues/themes to key bodies to inform planning and reform within the region. 1.2 To provide a mechanism to communicate about events, funding opportunities, initiatives and workforce capacity opportunities occurring in the region i. Promotion of opportunities via EMHSCA's membership email list and at Alliance meetings 1.3 Utilise EMHSCA's platform to facilitate coordinated and integrated Care in the region. Such as: i. EMHSCA members to support implementation of the Regional Integrated Mental Health, AOD & Suicide Prevention Plan. ii. Enable a Mental Health Stepped Care approach. iii. Support the implementation of the findings of the DHHS AOD Service Strengthening Project iv. Support the implementation of the findings of the MH Access and pathways project. v. Improve integration with the broader service system including family services, housing and homelessness, education, employment

			and social functioning. vi. Continue to promote the physical health and wellbeing needs of Mental Health and AOD consumers, ensuring linkages to their treating GP in the context of multi-sector collaborative care planning. vii. Work collaboratively with the Eastern Dual Diagnosis response to improve integration of Mental Health and AOD services.
2	**NDIS**	**Service system** Improved understanding of key NDIS workforce and marketplace issues, and agreed application of service coordination and support pathways between partner agencies. **Organisation** Improved understanding of importance of collaboration and role in supporting access to NDIS, targeted capacity building, and improved intra-service communication mechanisms and pathways to support. **Practice** Improved knowledge of staff role in NDIS. Improved knowledge of other key stakeholders. Improved capacity to support access to NDIS in partnership with consumers and carers, and other service providers.	i. Utilise EMHSCA's platform to keep up-to-date with NDIS transition progression ii. Utilise the Alliance to ensure clear and effective communication mechanisms, and improve collaborative partnerships, amongst EMHSCA partners, NDIA, LAC and NDIS service providers. iii. Provide up-to-date mapping of local NDIS and non-NDIS service provision.
3	**Safe and Quality Care**	**Service system** Shared understanding of key quality and safety issues, and agreed application of service coordination and care pathways between partner agencies. **Organisation** Improved knowledge of local issues, targeted capacity building, and improved intra-service communication mechanisms and pathways to support.	i. Support development of agreed care pathways and referral mechanisms for MH, AOD & suicide prevention in the region. ii. Maintenance of a shared learning space at Alliance meetings for sharing learnings/themes from adverse events (included as a standing item on EMHSCA Alliance agenda). iii. Supporting Alliance members to strengthen quality and safety practices.

		Practice Improved workforce capacity to deliver appropriate services in partnership with consumers and carers, and other service providers.	
4	**Collaborative Care Planning**	**Service system** Shared understanding of key issues, and agreed application of service coordination and care pathways between partner agencies. **Organisation** Improved knowledge of local issues, targeted capacity building, and improved intra-service communication mechanisms and pathways to support. **Practice** Improved workforce capacity to deliver appropriate services in partnership with consumers and carers, and other service providers.	Promotion of collaborative care across all EMHSCA members and the broader MH and AOD sector i. Continued implementation of the shared care protocol and monitor partners' progress. Seek to simplify the mechanisms for auditing progress. ii. Support GPs' active involvement in the care team.
5	**Workforce Development**	**Service system** Maintain and further develop a skilled workforce in the region. **Organisation** Enhanced opportunities to recruit and develop a skilled workforce who know how to work across sectors effectively. **Practice** Improved workforce capacity to deliver appropriate services in partnership with consumers and carers, and other service providers.	Utilise EMHSCA's platform to drive high quality multi-disciplinary care for MH and AOD consumers in the region. Such as: I. EMHSCA to provide a mechanism to communicate about events and initiatives that support workforce development. II. Ensure available training resources are shared on the website, including information about orientation in the region, collaborative care and dual diagnosis issues. III. Share recruitment opportunities across sectors to build the workforce in the east. IV. Deliver on the workforce initiative as per EMHSCA contract.

The EMHSCA Care Coordination Model

Figure c EMHSCA Care Coordination Model



The EMHSCA model of Care Coordination has emerged from a thematic analysis of data collected via interviews conducted with EMHSCA leaders (16) and staff (19), Peer Support Workers (4), consumers (10) and carers (10). The following 5 aspects of Care Coordination were consistent themes across all study cohorts and as such form the structure of the EMHSCA model.

1. The consumer as central

The consumer as the centre of their care is a concept that is commonly understood within service coordination models and MH Recovery frameworks (Commonwealth government 2013; PCP Victoria 2012, pp. 23-24). An understanding of this concept was conveyed by many of the staff and leader participants in this study. When the consumer is central to the work and they are well engaged it is their goals that guide the composition of the care team. From this study it was clear that a tailored approach for each individual is required if staff are going to engage consumers effectively.

2. The importance of the human touch

Many people accessing services have been traumatised at some time and the effects can be enduring (Marel et al 2016, p.113). Consumers said they need a gentler approach to care and less stimulating environments which will enable them to work with service providers. Being visited at home can reduce the barriers for people in accessing supports and enable relationships to develop that enable a team approach to care planning.

The value of having workers with a lived experience of MIH was mentioned multiple times by every cohort. Consumer participants outlined the value of the staff with lived experience, known as Peer Support Workers (PSWs), as having the ability to understand and empathise with people who are experiencing symptoms of MIH. It appeared from the data that consumers found it easier to trust PSWs, possibly because they felt they were understood. 'I know one (staff member) cares coz we talk. And she's been where I've been' (Participant 22).

3. Sharing and owning: the importance of teamwork

Flatua et al (2013, p.97) found that there was 'significant overlap' of consumer characteristics across service sectors and recommended a need for improving inter-service communications. For the current study, staff and leader participants valued cross-sector work and described the utility of connecting consumer's supports as: the clarification of various roles and expectations; mutual respect; more creative problem solving; clear communication mechanisms; a sharing of any safety issues; and improved continuity of care for people. Care team meetings were seen to encourage a more holistic view of the consumer's situation and support person-centred care. Staff and leaders spoke about the importance of having just one care plan for the consumer to clarify responsibilities and show how all supports fit together to enable the person's goals. This is a key aim of the Service Coordination Framework outlined by PCP Victoria (2012, pp.22-23).

Consumers voiced that the coordination of supports is important to them, especially when they are experiencing exacerbations in MIH, as it lifts some of the burden of engagement at more challenging times. Rollins et al (2018, pp.8-9) asked consumers about how they manage co-occurring severe MIH and physical health issues and their views on CC and found that they viewed CC as convenient. Consumers appreciated friendly and knowledgeable staff and efficient communication between providers but said they would like more responsive communication from services at times (Rollins et al 2018, pp. 8-9). Flatau et al (2013, p.94) found similarly that consumers appreciated CC as it reduced confusion and the uncomfortable re-telling of their stories.

Carers described their desire to have their role acknowledged by staff and to have more open communication with the care team, which aligns with findings by Olasoji, Maude and McCauley (2017). In many cases the carer is the main person involved in the consumer's life and they carry the greatest burden of responsibility and knowledge in the care team, apart from the consumer themselves.

4. The importance of connections and networks

A strong theme emerging from the data across cohorts was of the need to build the knowledge and capacity of staff to work more collaboratively and to provide a high-quality service to consumers. Broadbent and Moxham (2014, p.232) demonstrated that it is easier for staff to interact across services and sectors when they are aware of the cultural differences and have some knowledge of the language required to reach a shared understanding of the consumer's needs. Network meetings and shared training provide useful opportunities to connect and educate staff for this purpose (Broadbent & Moxham 2014; Crotty, Henderson & Fuller 2012, p.216; King et al 2013).

The importance of the regional alliance in uniting services, sharing information and problem solving was outlined by many participants across staff and leader cohorts. Additionally, the importance of a personal relationship with other providers was highlighted and the view commonly held that effective coordination of supports is person dependent. This idea is supported by studies by Banfield and Forbes (2018), Crotty, Henderson & Fuller (2012), Green et al (2018), Groenkjaer et al (2017), and Overbeck, Davidsen and Kousgaard (2016) who all found there was a need for personal relationships to enable CC, with most identifying specific traits of staff that enhance relationship development.

According to Flatau et al (2013, p.96), modes of integrated care include internal provision of multiple services, and external collaborative partnerships. Recommendations regarding service integration included the need for 1. effective models of integration for people who have complex needs; 2. development of structural mechanisms within service networks to assist with sharing policy, protocols and care plan documents; 3. improved cross-sector communications and connectivity; and 4. governments should better meet the associated costs of these measures (Flatau et al 2013, p.97).

5. The importance of resourcing

The findings of this study support the need for a systematised suite of supports to simplify the journey for consumers and to enable staff to provide appropriate long-term planning and referrals. The current system is fragmented with no central point of navigation for people.

Several studies concluded that a well-resourced service system enables CC (Banfield et al 2012, p.156; Cranwell 2017; Groenkjaer et al 2017). Consumers report that when staff are busy and task focussed, they are not getting the person-centred support they need, and the human touch is lost. Services need to be flexible and tailored to the individual's needs to enable consumers to engage. Carers shared these perspectives and added that staff only seek to collaborate with carers when consumers are in crisis.

Staff and leaders reiterated the importance of being well resourced to provide responsive and coordinated services and said that when there are insufficient staff hours it is not possible to work as a care team across services. An important development to support CC would be the introduction of key performance indicators linked to collaboration. A number of studies conclude that outcome measures are required to evaluate various CC efforts (Banfield et al 2012; Ehrlich et al 2009; Flatau et al 2013; Frost et al 2017).

A range of barriers to Care Coordination were identified. These included 1. Rigid models and approaches; 2. An unnavigable service system; 3. Hierarchical ideas and behaviours; 4. Stigmatisation. The EMHSCA work aims to address these barriers moving forward.

Glossary

AOD: Alcohol and Other Drugs

Carer: family members or friends of a consumer who provide care to the consumer within their relationship as defined by the Carers Recognition Act 2012. Carers may not necessarily live with the consumer for whom they care. Children can be carers too.

Collaborative: 1. Two or more people or organisations working together for a particular purpose. 2. All parties to the recovery plan participate as equals in all processes of coordinated shared care required.

Consumer: a consumer, who has been diagnosed with a mental health illness, has direct experience of Mental Health Services or identifies as a consumer [VMIAC's definition]. The term "consumer" refers to people who directly or indirectly make use of mental health services.

DDCCAC/WG: Dual Diagnosis Consumer and Carer Advisory Council and associated Working Group. These in-tandem groups (peer and staff) work together to support the Eastern Metro region Dual Diagnosis Response.

DHHS: Department of Health and Human Services

Dual Diagnosis: Term used to describe co-occurring Mental Health and Substance use issues.

Dual Diagnosis Linkages: A front line health and community staff linkage which meets monthly across at rotating sites across the inner and outer eastern region to network and capacity build.

EMPHCC: Eastern Melbourne Primary Health Care Collaborative

EMPHN: Eastern Melbourne Primary Health Network

EMR: Eastern Metropolitan region of Melbourne – includes both inner and outer east regions.

EMR Dual Diagnosis Response: A collective term to describe the various aspects of the work of the Eastern Dual Diagnosis Service which includes the DDCCAC/WG and the Dual Diagnosis Linkages.

Eastern Mental Health Service Coordination Alliance Services (EMHSCA): All Eastern Metropolitan Region of Melbourne services involved in the provision of care to people with a mental health concern and who have signed the EMHSCA Memorandum of Understanding 2013.

LAC: Local Area Coordinator – NDIS partner service – Latrobe Community Health Service in the Inner and Outer east.

MHCSS: Mental Health Community Support Services. Prior to November 2017 they provide non-clinical support for people with Mental Health illness throughout their recovery journey to manage and achieve a broader quality of life. Now providing psychosocial disability supports as NDIS providers.

MOU: Memorandum of Understanding

NDIA: The National Disability Insurance Agency (NDIA) is an independent statutory agency, whose role is to implement the National Disability Insurance Scheme (NDIS).

NDIS: The National Disability Insurance Scheme provides community linking and individualised support for people with permanent and significant disability, their families and carers.

PCP: Primary Care Partnerships
Recovery Plan: A consumer's plan that articulates what is important in their life and includes their goals, hopes and dreams, and identified supports (Glover 2013).