

# Mental Health Co-morbidity Shared Care Project & Transition to MHNIP

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# Presentation Outline

- Project Aims
- What did clients receive as services
- What benefits did the GP's receive
- From Project to MHNIP

# Project Aims

- To identify and work with people with a diagnosed mental health problem and combined substance use.
- Facilitate coordinated care between the client, GP, Area Health Service and other agencies.
- Provide an opportunity for GP's to better care for clients with co-morbidities via communication about client progress, suggestions.
- Increase GP's knowledge and confidence in caring for these individuals.
- Provide the individual with education and support.

# Project Aims

- Provide ongoing physical assessments on each client which can be discussed with the GP.
- Provide the client with a range of individualised therapies and referral to adjunct services after a comprehensive assessment.
- Involve carers of clients with mental health problems and combined substance use and provide education and support in caring for the client.

# What services has clients received?

- Referral to inpatient detoxification.
- Home Detoxification ( after assessing dangers)
- Supportive counselling. SFBT. CBT. MI.
- One on one intensive relapse prevention.
- Brokerage Services.
- Employment support.
- Legal support.
- Centrelink assistance.
- OTP placement.

# What services continued

- Phone contact for after hours service if required.
- Assistance with housing.
- Carer assistance and support.
- Assistance with school ( such as free tutoring and payment of materials for HSC).
- Harm Minimisation education
- Sexual health screening
- Assistance with tobacco cessation.
- Medication reviews.

# What services continued

- Individual plans that were tailored for the client that would provide the best outcome.
- Coordination between GP, Client and Psychiatrist
- Continual positive reinforcement of progress made
- Visits with clients were held in their own home, within the general practice, café's etc. Wherever the client felt most comfortable. Familiar territory and a feeling of safety for them.
- Practical approaches.

# What did GP's receive ?

- Time . The essence of good care.
- Updates showing client progress via phone and reporting
- Education, advice on medication.
- Support
- Confidence. Due to the often separated services between mental health & drug and alcohol. Links between services by the coordinator.
- Reassurance that the client was being cared for holistically. Felt that their contribution was validated.

# GP's continued

- Due to working in the practices, notes were written directly into the clients notes.
- GP was always aware of what had occurred at each session.
- Able to suggest or remind GP about pathology and other physical testing.

# A GP Perspective!

## To Whom It May Concern

### **Re: Mental Health Shared Care Co-morbidity Project**

Adam Rice from this project has been working in our practice over the last 6 months. We have had a number of patients helped significantly. I have for example a 50 year old patient with schizophrenia. He is Hepatitis C positive, uses intravenous drugs, smokes heavily and has a multitude of social problems. He has often failed to arrive for appointments. Adam has been able to help him with his social issues and dealing with the public trustee, enabled and co-ordinated him onto a drug detox program and supported and encouraged him to give up his smoking - alas not yet successfully. I have neither the time nor resources to be able to do this, and am very grateful on behalf of my patient for the program and the care provided.

# What did Clients say?

- Didn't have to tell the same story over and over again as the coordinator had already made each clinician aware. ( info sharing)
- Felt supported.
- That the service was continual.
- Family understood better.
- Felt non judged.
- Had ownership over their problems due to knowing they had support.

# What next?

No further funding

GP's initial fear of no ongoing funding realised!

Where do the clients go?

Over 50 clients, over 220 OOS

80% retainment of mental health, comorbid clients.

# Is there a place for MHN in Divisions of General Practice

- Answer is YES
- Both GP's and clients benefit
- GP's have trust in their Division, lets facilitate this!
- GP's feel its not a losing battle with MH, D&A Clients.
- GP's want to be able to provide the best care in their limited time.

# From MHSCCC to MHNIP

## Challenges :

- Demand management.
- Approval from the Divisions Board Members
- Meeting Medicare requirements
- Informing current clients of changes.

## Benefits from MHSCCC to MHNIP

- Client caseload already established.
- Ongoing care coordination and case management.

# What changes?

- 10 sessions per week versus unlimited time per week
- Will not be centred in practices, so info sharing will be less.
- Increase in numbers of GP's accessing the service (demand increase)
- 6 GP to many
- Reporting requirements
- Deal with change as it occurs
- Implement a 3 session assessment phase

# The Future

- MHN, GP, LHN cohesion
- Exciting
- A new vision, MHN making a direct impact on PC
- A new and valuable way MHN can practice within a primary care framework &
- Formulating a basis for MHN to feel confident in practicing independently