



***‘Success so far’***

# **Mental Health and Drug & Alcohol Shared Care Clinical Coordination Project - Pilot**

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**Quality  
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# Overview of the project



In July 2010 NSW Health funded GP NSW to deliver a 12 month pilot program:

## **‘Mental Health and Drug & Alcohol Comorbidity Shared Care Clinical Coordination Pilot Project’**

Integration of Physical Health, Mental Health and Drug & Alcohol Comorbidity



# Origin



## **The next step:**

- Developed in response to need identified in previous comorbidity programs implemented and evaluated by GP NSW

## **Modeled on:**

- Similar successful Mental Health programs in other states of Australia

## **Unique:**

- Focus on Physical Health + Mental Health + Drug & Alcohol Use

# Objectives



- Enhance the **physical and mental health outcomes** of patients with comorbid MH and D&A issues who are living in the community
- Increase the number of people with MH and D&A disorders who receive care delivered in a **shared care model of practice**
- Increase the **capacity of General Practitioners to support people** with MH and D&A issues in the community
- Improve **communication, collaboration, networks and referral pathways** between GPs, mental health services and drug and alcohol services and other relevant services which aims to **provide an integrated system of care.**
- Provide **early intervention, coordinated care, information and referral services.**

# 10 NSW Divisions



5 Urban + 5 Rural Divisions:

1. Central Coast Division of General Practice (Gosford)
2. Central Sydney General Practice Network (Ashfield)
3. Dubbo Plains Divisions of General Practice (Dubbo)
4. Illawarra Division of General Practice (Wollongong)
5. Mid North Coast Division of General Practice (Coffs Harbour)
6. Northern Sydney General Practice Network (Artarmon)
7. NSW Central West Division of General Practice (Bathurst)
8. Riverina Division of General Practice & Primary Health Ltd (Wagga)
9. Southern General Practice Network (Goulburn)
10. St George Division of General Practice (Hurstville)

# Diversity

Local services: Mental Health, D&A, GPs, NGOs, other

Politics: Driven by population, exist in & between services

Populations: culturally diverse, social issues, trauma

Geographical areas: large



# Why?



Patients with mental health and drug and alcohol comorbidity:

- frequently move between services without appropriate **referral or continuity of care**
- are often **discharged** from acute services into the care of general practice without appropriate **care coordination**
- who present to general practice often **need additional support** for their **complex needs** support their **recovery**
- these patients can be more effectively managed in primary care settings if **services** were able to provide **coordinated and shared care**

# Aims of the project

At the General Practice level:

- Improved **clinical assessment, treatment and service coordination** for people with mental illness and drug and alcohol disorders
- Address **physical health** needs
- Increase **drug and alcohol screening**
- Provide **treatment options and service integration** for patients experiencing alcohol and drug misuse



= ***“A (complex) problem shared is a problem halved”***

# Why Shared Care?

Possible solution to the problem to existing service gaps

Key elements:

- **Collaboration**
- **Communication**
- **Coordination**

= Cooperation & Teamwork



Patient focussed and involved

Team share and coordinate care individualised for the patient

# Shared Care Clinical Coordinators (SCCC)



13 SCCC across NSW:

3 Psychologists working at headspace sites

10 Mental Health Nurses (MHN) in General Practice

Role:

Provide clinical services

Facilitate service coordination\*



\*(teamwork and service integration required)

# Workforce Development



- Clinical Supervision
- Clinical Placements
- Continuing Professional Development: onsite and offsite
- Network
- ACMHN Credentialing
- Comorbidity: A new career pathway
- Opportunities for undergraduate nurses to access community based clinical placements

# Service Integration



The pilot project aimed to influence and achieve service integration at 2 levels:

## **General Practice level**

GP and SCCC work as a team

120 GPs (R=69:U=51) engaged in the project – referral &/or shared care

## **Local services level**

Improved collaboration, communication, networks & referral pathways developed by forums, Project Activity Groups, MOU's, surveys



# Evaluation Methodology



## **Australian Drug Foundation**

Patient feedback

GP surveys

SCCC interviews

## **Clinician data collection (CDC)**

Demographic data

Mental health assessment, D&A screen, physical health assessment, occasions of service, functional assessment

# Results



## Australia Drug Foundation

Measuring project objectives

Results from patient feedback form

Completed by 37 patients

Written survey at end of first appointment

Feedback re SCCC skill and engagement

# Results - ADF



## **Australia Drug Foundation: patient survey – >80%**

Listened carefully to patients symptoms

Asked about health history

Discuss treatment options

Explained drug and other treatments, their expected effects, possible side effects

Encouraged to ask questions about their treatment

SCCC satisfactorily answered questions

Gave advice if their symptoms changed

Told them to reschedule a return visit

Treated them in a professional manner

# Results - CDC



Referrals: 400

GPs: 120 (R=69; n=51)

Received from:

Mental health services, including Adult, Child & Adolescent, D&A services, NGO's, gaols, homeless agencies

Sites/special populations:

- headspace
- General Practice
- Aboriginal Medical Service

Creation of a variety of Share Care Models

# Results



Interventions: 1124

- Early intervention with young people
- Responsive to patient need
- Evidenced based: relapse prevention, recovery orientation, CBT
- Home detox
- Addressing trauma

Coordinating care: Referrals to existing services & providing service

What patients say:

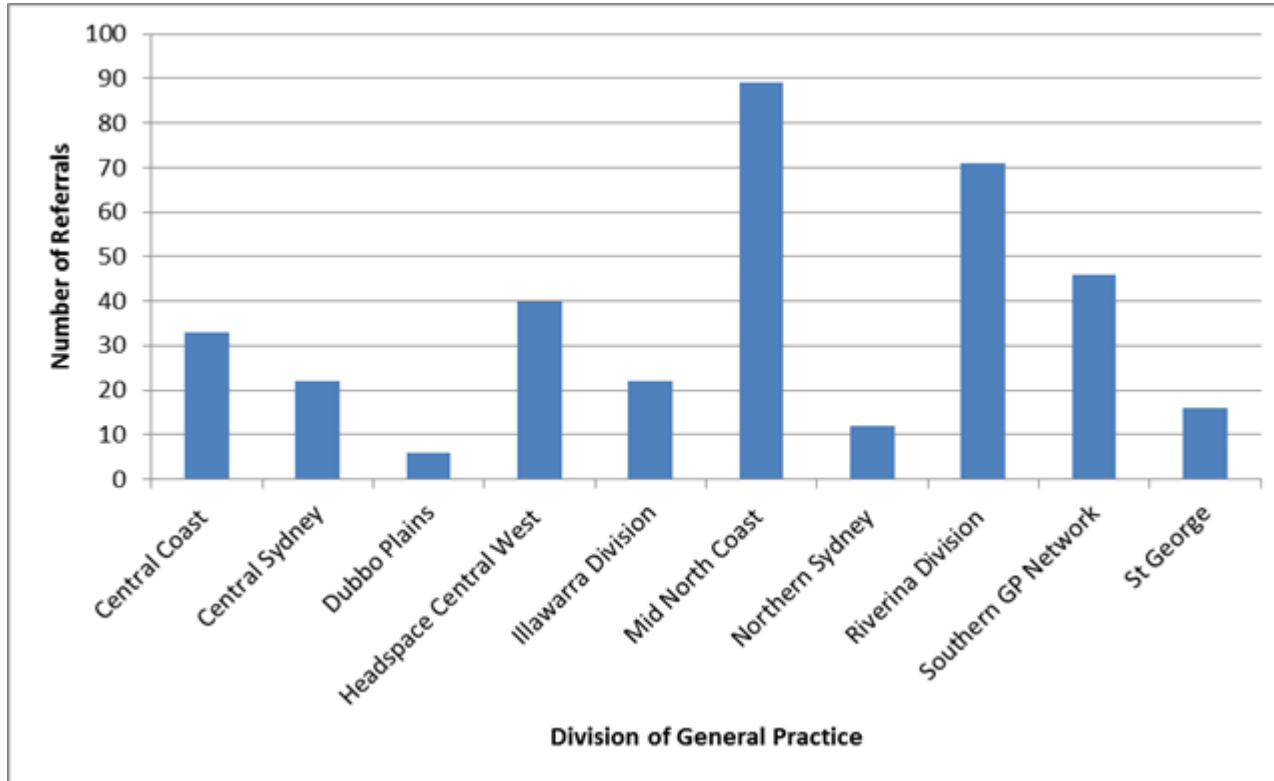
Like the discreet nature of the service

One setting “Glad not to repeat my story”

Improved overall health = Right time/right place/right approach

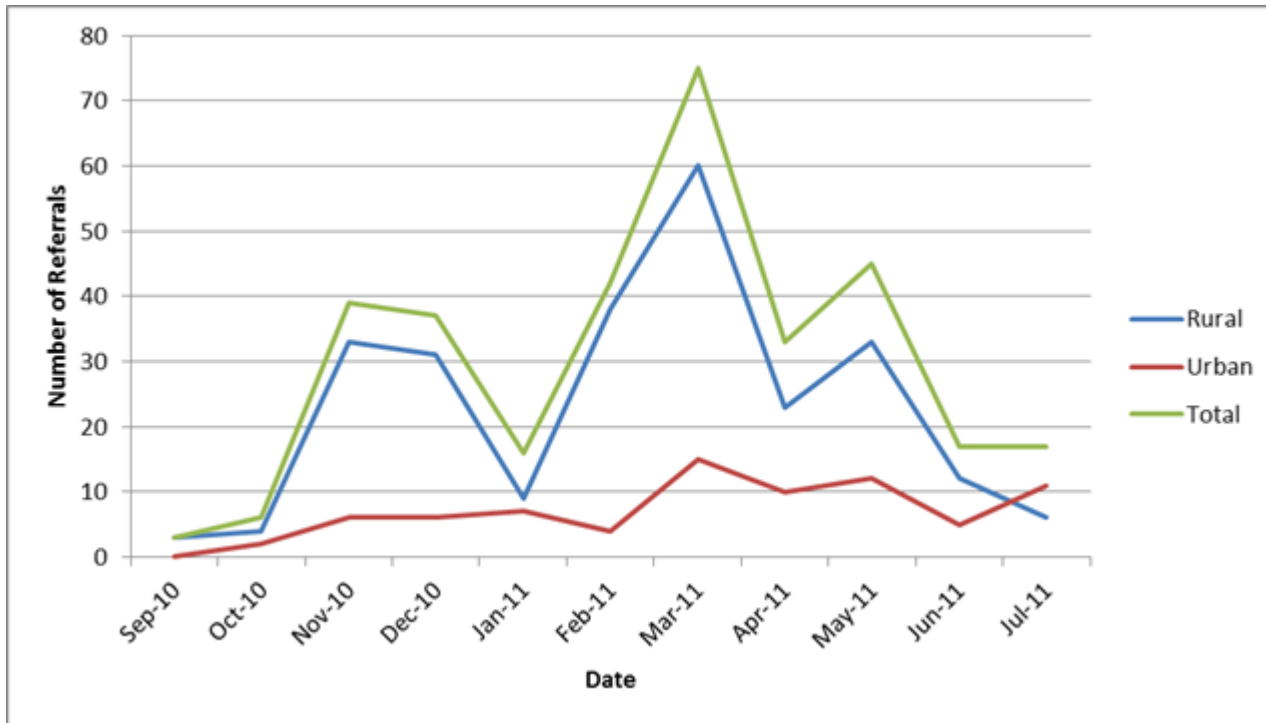
# Results

## Distribution



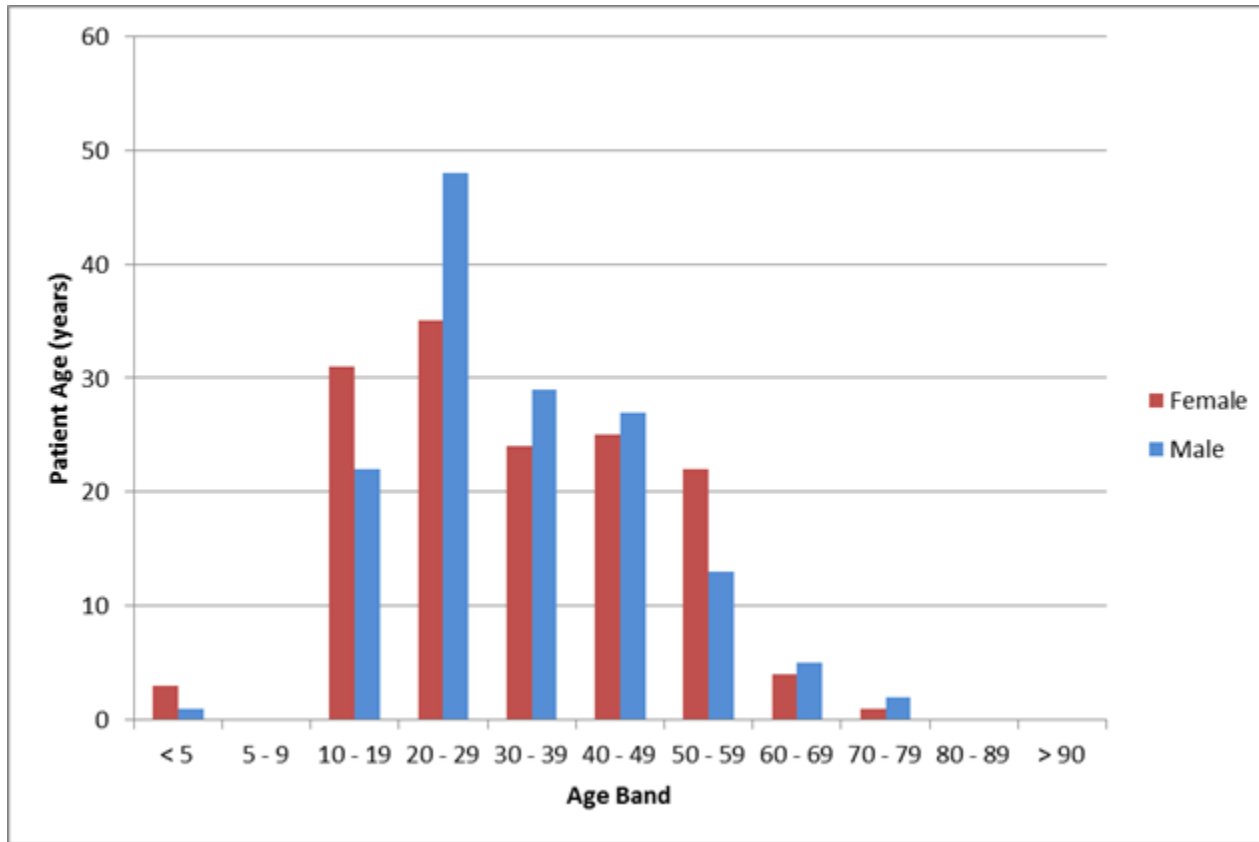
# Results

## Referral trend



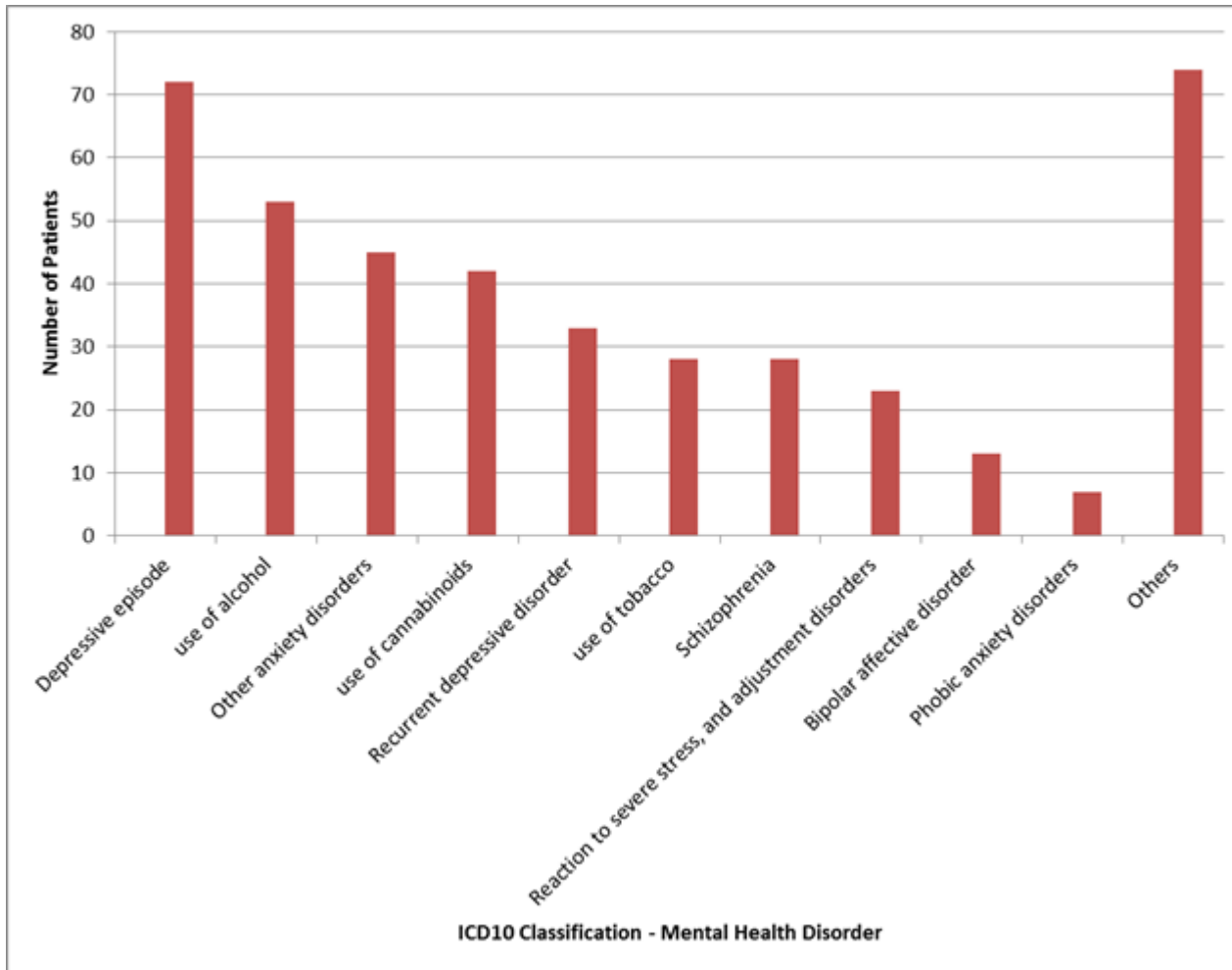
# Results

## Age and sex distribution



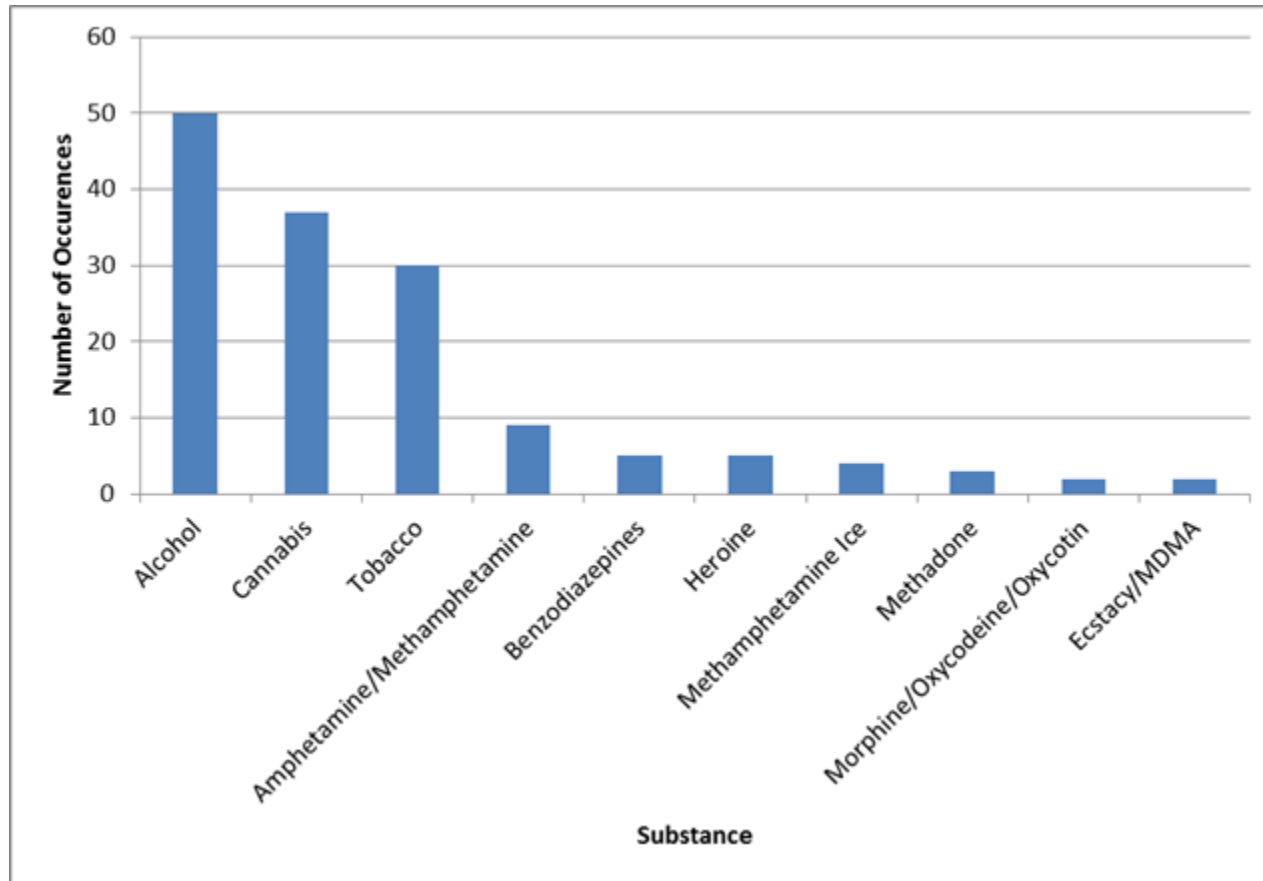
# Results

## Top 10 Mental Disorders



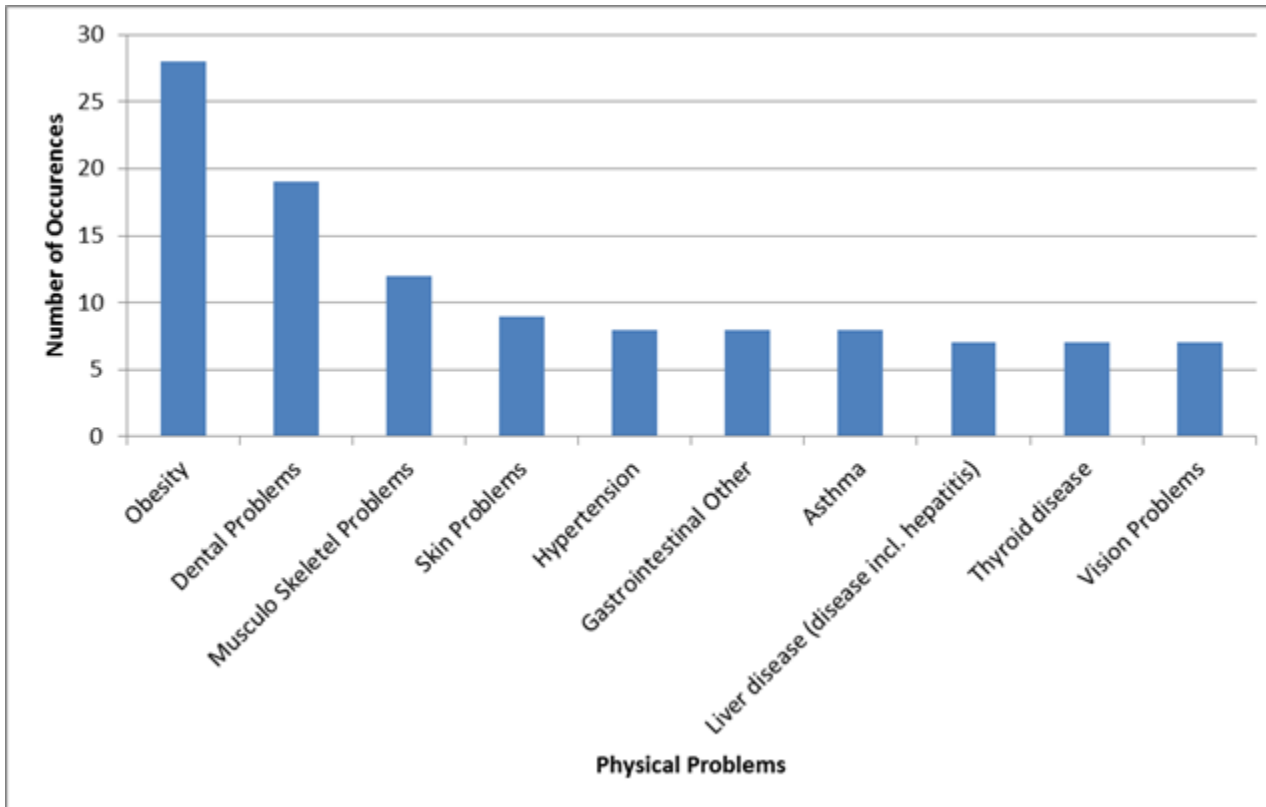
# Results

## Substance used



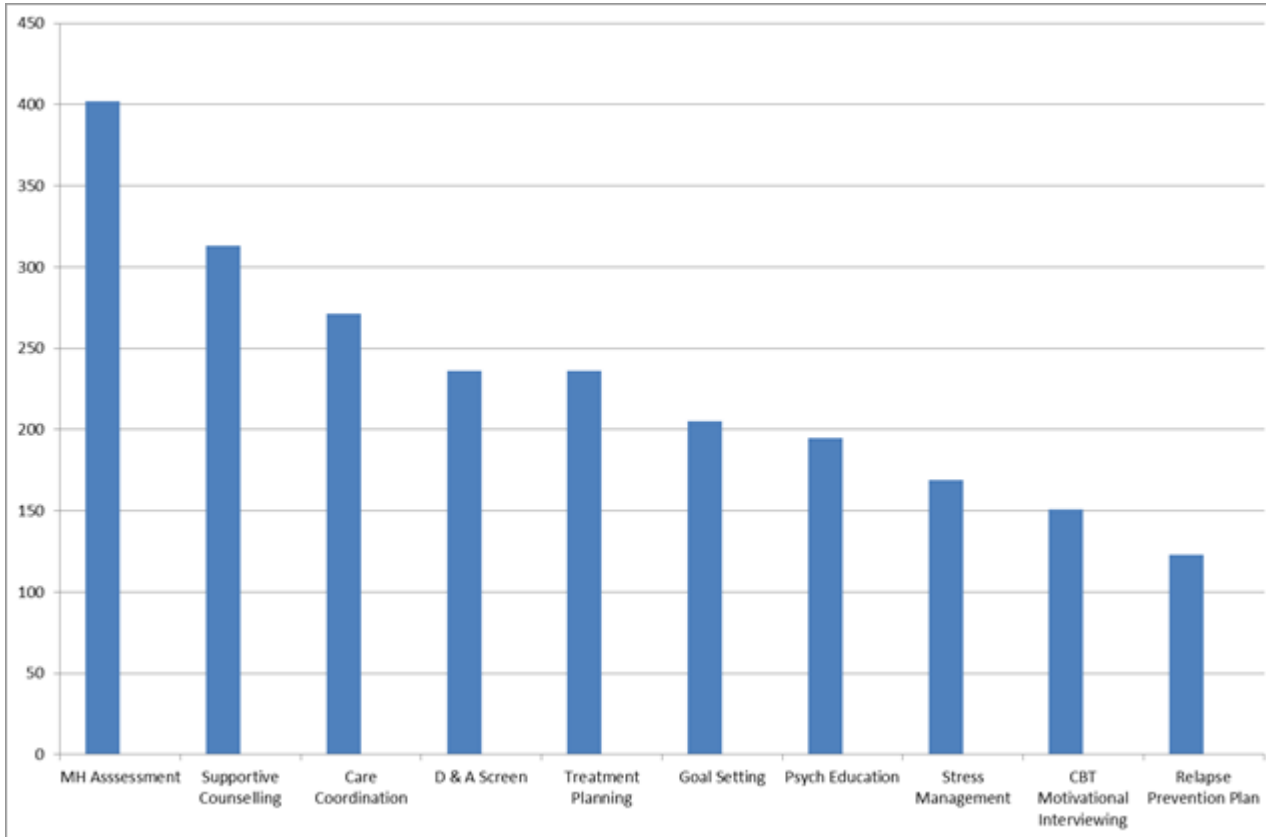
# Results

## Physical health problems



# Results

## Interventions



# Results



## Summary

- Young people 10-29
- 30-60 year olds well represented
- People with chronic mental illness (referred from MHS)
- People with chronic drug use (referred from D&A; General Practice)
- Indigenous people
- Homeless people

# Results



## **Clinical samples collected illustrate:**

- Cycle of decline: trauma – substance use to avoid pain – risky behaviours – decline in function &/or trouble with police
- People with MH and D&A comorbidity have complex needs: take time, effort and resources over considerable period to rehabilitate
- People with MH and D&A can have multiple physical health issues
- Social impact of D&A is significant
- Poor access to appropriate services
- Engagement and commitment to change is key to success for these patients
- Existing services cannot offer long term programs
- Support and psychoeducation key treatments

# Results



## **Findings:**

Comorbidity vs Multimorbidity

## **What has been the impact?**

Move people through difficult periods

Addressing underlying trauma

Reducing hospitalization

Long term care

Getting people off drugs

Improving social impact: family relationships

Homeless of the streets

Detox: at home and inpatient

Exercise

# Conclusion

**The Shared Care Model so far has been effective:**

- fills a gap in services
- Influences service integration and communication
- can be adapted to varied settings
- reduces isolation for GPs
- improves outcomes for special populations

