aspex consulting

EASTERN HEALTH

Integrated Health & Social Services Response - Youth Mental Health

STAGE 1 REPORT

Final Report

23 October 2019

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LIST OF ABBREVIATIONS

CALD	Culturally and Linguistically Diverse
CSQ	Client Satisfaction Questionnaire
CYMHS	Child and Youth Mental Health Service
DHHS	Department of Health and Human Services
EMP	Eastern Metropolitan Partnership
EMPHN	Eastern Melbourne Primary Health Network
GP	General Practitioner
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or Questioning
NDIS	National Disability Insurance Scheme
NMDS	National Minimum Dataset
PARC	Post-Acute Recovery Care
PROMS	Patient Reported Outcome Measures
PRO-PM	Patient Reported Outcomes – Performance Management
PWG	Project Working Group
VAGO	Victorian Auditor General's Office
Y-PARC	Youth Post-Acute Recovery Care
YETTI	Youth Engagement and Treatment Team Initiative

DISCLAIMER

Executive summary

The purpose of this project is to develop an integrated client-centred and place-based service delivery model that provides seamless access to health and social support services to youth aged 12 to 25 years **in the Yarra Ranges**; in particular focusing on young people in need of mental health services.

The proposed integrated service model is a new way of engaging with clients and their families and carers and for services to be delivered.

The model is built around the needs of the client, with seamless access and transition to and from multiple health and social support service providers. It requires collaborative inter-entity relationships to be formally established, strengthening local leadership and governance structures, the pooling of available (Commonwealth and State) funding, and enhancing ICT capability to support the sharing of client-level data.

The model represents a significant change to the way the system currently operates.

KEY ISSUES

The need for a new model of integrated health and social support services in the Yarra Ranges was driven by several key issues that were identified through a literature review, stakeholder consultations and analysis of local health and population data.

The main drivers of the model include the need to address:

- A health and social service systems that is seen to be difficult to ***access and navigate***. Specifically, there is a lack of a recognisable ***entry point(s)*** for many vulnerable people for accessing health and social support services with the consequence that some people fail to receive services;
- Perverse incentives that work against ***coordination and cooperation*** between service providers, including current funding models;
- ***Service gaps***, particularly prevention and early intervention services, and a lack of suitable (intensive) community mental health support options; and
- Under-developed ***system direction (stewardship) and effective governance and leadership.***

A consequence of these factors is ***siloed and fragmented care,*** which represents a *structural weakness* in the current service delivery system. This system fragmentation is seen to be particularly challenging due to the multiple service providers, variable referral pathways, unclear role delineations and varying sources of funding.

In summary there is a strong case for change.

Additionally, the proposed service delivery model seeks to respond to several recent policy and societal imperatives including the Royal Commission into Family Violence and anticipating and preparing for the potential outcomes from the Royal Commission into Victoria's Mental Health System, amongst others.

A snapshot of current service system issues, proposed changes garnered through an integrated model and envisaged improved client outcomes is illustrated in Figure ES-1.

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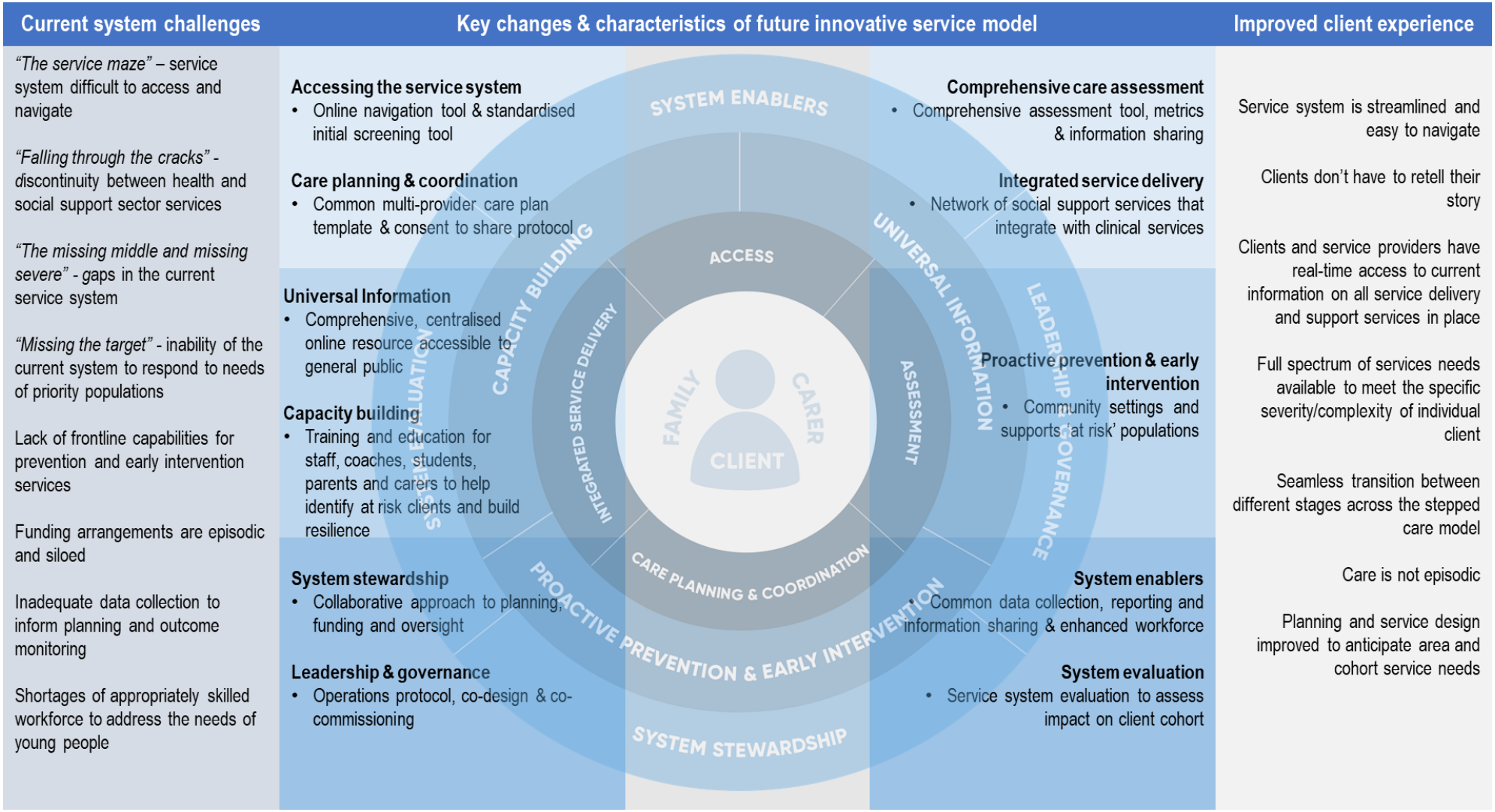
Figure ES-1: Improved client outcomes to be achieved through an integrated service model



INTEGRATED SERVICE MODEL

The proposed integrated service model has at its core, the young client and/or family/carer. The model is client-centred and provides holistic wrap-around services that meet the client's particular health and social support needs.

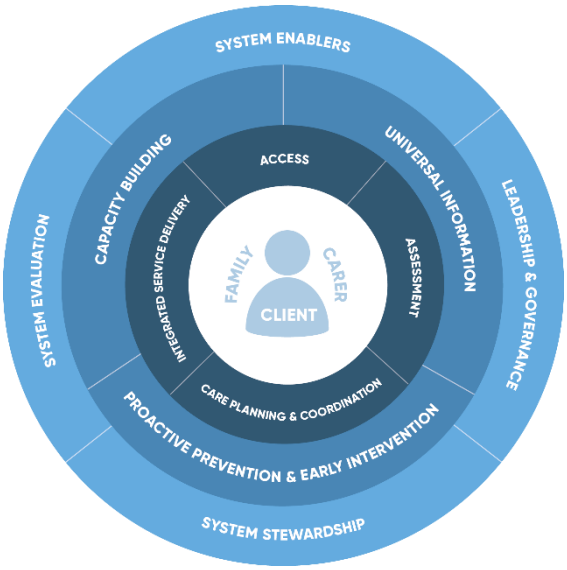
There are three levels of the service model, illustrated in Figure ES-2.

- **Level 1** is the planning and delivery of tailored, integrated services directly to meet client need. The direct and tailored services have three elements:
  - ***Access***. This includes:
    - 'First contact' with any of the participating entities in the project;
    - Screening and Initial Triage; and
    - Referral (as required). This includes 'warm referrals' and actual appointments with referred entities, phone discussions, and/or teleconferences at the time of first contact.

    The model also recognises the value of a 'trusted person' and/or service navigator for clients.
  - ***Comprehensive Assessment.*** Most clients, and all complex clients, and their families/carers will require a holistic needs assessment. This includes a range of primary and secondary health services, and social support service providers.
  - ***Care Planning and Coordination***. There is an expectation that all clients will have a 'plan', and that all complex clients not assessed as capable of self-management will have care coordination.
  - ***Integrated Service Delivery***. There is an expectation that all services, including acute, primary care, residential, community-based services, and social support services are integrated and holistic, based on the client's assessed needs.
- **Level 2** is the provision of services aimed at clients and families **but are not tailored** for the individual client. These services seek to inform and raise awareness across the community and are accessible/available in the public domain. These services focus on reaching the broader local population for awareness and 'at risk' cohorts for health promotion and early intervention. These services have been categorised as:
  - ***Universal information*** on youth mental and physical health and wellbeing including people to talk to, and avenues for seeking specific help. This requires ensuring a repository of publicly available information that is likely to include information on social determinants, risk factors, health behaviours, together with more specific information on mental health conditions, treatment information, local service types and locations and how to access or refer to a service. In effect, how to access the system.
  - ***Prevention and early intervention***. These are proactive measures targeted at 'at risk' groups and refers to services that inform and educate and facilitate early intervention.
  - ***Community capacity building***. This is enhancing capacity of professionals such as teachers and coaches who work with young people to recognise signs and symptoms; and with professional health providers who are not trained as mental health professionals. This includes the staff of all engaged entities and individual providers working within the Yarra Ranges.
- **Level 3** provides system service structures and supports, considered essential for the service model to operate effectively. It includes the supporting architecture of the service system within which the integrated service delivery model needs to operate. These are services categorised as:
  - ***System stewardship***. This provides the broader framework within which the policy makers and funders establish the operating parameters, performance levels and accountabilities.

- ***Leadership and governance***. This provides the local mechanism for developing and managing the service model. Two key features include:
  - An over-arching *Strategic Agreement*. This Strategic Agreement is an acknowledgement and commitment by all participating entities to the principles and objectives of the service model. It includes commitments to shared care, collaboration and accountability frameworks, amongst other things;
  - *Operational Protocols Agreement*. This Agreement establishes the basis for the day-to-day guidelines, protocols and behaviours of each entity in the program. The Operational Protocols Agreement sets the entry, triage, assessment, referral, planning and delivery guidelines, with particular emphasis on common approaches, collaboration and integration, and client involvement in their care plan.
  - The Operational Protocols Agreement would include *a mechanism for local problem solving as issues arise,* such as a local governance or coordination group of all the participating entities.
- ***System enablers***. These are the enablers that can support and sustain a local service model. This would include, but not be limited to:
  - *Design of supporting tools*. These tools would be used by all entities in the project, and they may be stand-alone tools, or 'bolted-on' tools to existing databases used by the various entities, including an initial assessment and triage tool, a (central) client/family contact register, client care plan and care coordination register, client risk tools, including self-management capability, care plan and care coordination repositories, 'trusted person' and service navigator registers;
  - *Reform of funding approaches/models*. There will be a need for funding models to be developed that reinforce the integrated care model. This will focus on client-level funding systems that enable 'bundled payments' for services delivered by potentially several service providers; and
  - *ICT enablers.*
- ***System accountability and evaluation***. These are the specific measures and service expectations set for all entities, including but not limited to:
  - The development of performance measures, including client experiences and outcomes;
  - Service *activity and service cost* data sets and reporting; and
  - *Program evaluation.*

Figure ES-2: Service Model Framework



The service delivery model brings together many of the features identified in the literature and existing models of care. An important feature of the model is that its composition is *function-based*, or a tailored service, rather than funding or program based. A function-based model is considered superior as it best enables a stepped care, client-focused and integrated approach.

MAKING THE SERVICE MODEL OPERATIONAL

The integrated service model described above has broad support in its concept and for its design features. However, the innovative elements of the service model are **not** in the model design and description of the framework.

The innovation is in the development of effective inter-relationships between service providers, and changes to existing work practices necessary to achieve a service model that enhances client outcomes.

This includes, amongst other elements:

- Ensuring **service pathways** that require multiple service providers deliver an integrated and seamless service. *[The model moves the service delivery system away from an entity-based focus that fits clients within the organisation's parameters and constraints to one that has the client at the centre of care];*
- Developing **a strong focus on the 'front-end'** of the model, namely service access. *[The model fundamentally changes the current system and creates unprecedented opportunities for early access to services]*;
- Building-in system support mechanisms that **enable/reinforce sustainability** and foster inter-entity collaboration. *[This includes elements such as effective local governance and operational problem-solving capability, setting explicit program expectations, developing and enhancing information technology, and introducing flexible innovative funding models]*; and
- **Accountability for outcomes**. The model explicitly builds in accountability and performance measures that support the key elements of the model. *[This includes very different measures compared with the current system, including meaningful performance measures on integration, timeliness of care, seamless service provision, and client outcomes/experiences]*.

The essential change of this service model is that it builds client-centred approaches to care and moves away from the current approach of entity-centred care, whilst breaking down siloed practices. It subordinates the interests of the entity objectives and promotes client interests.

Any one of the above developments would represent a significant change to the existing service model. All the changes represent an exciting and bold innovation in how services are developed and delivered.

Evaluations of similar models that promote care integration within and between service providers acknowledge that relative success or failure is a function of the willingness of entities to collaborate as well as effective implementation. These two factors in particular are expected to be a major challenge.

1. Context

This report has been prepared for the Eastern Metropolitan Partnership (EMP) by Aspex Consulting.

1.1. BACKGROUND

The EMP is an advisory group that assists the local community to engage directly with state and local governments and advise on the top priorities for jobs, services and infrastructure within the eastern metropolitan region.

The EMP undertook community consultations relating to the health and social service systems. These consultations suggested that one of the main concerns is the difficulty in navigating and accessing health and social services, resulting in many vulnerable people having poor access, and some not accessing services at all. The EMP's advice to government for 2018 therefore included a focus on *integrating health and social services, specifically improving access to the full range of health and social services for the region's most vulnerable people.*

The EMP engaged Aspex Consulting to work with stakeholders to develop a model of integrated health and social services for a client cohort experiencing fragmented care, who met the following criteria:

- Below the age of 75 years, where there are opportunities for early intervention for chronic diseases and/or early death may be avoided through effective interventions;
- At-risk of potentially preventable or treatable conditions (that may result in potentially preventable deaths); and
- Screening and primary prevention opportunities that can reduce the chance of premature death.

1.2. PURPOSE

Discussions with the Project Working Group (PWG), established to oversee this work, and analysis of local population and health and wellbeing data, resulted in the selection of integrated health and social services for ***youth with mental health needs*** in the Yarra Ranges as the client cohort.

> *Thus, the purpose of this project is to develop an integrated, client-centred and place-based service model which delivers seamless access to health and social services to youth with mental health needs in the Yarra Ranges*

Many of the model elements can be more broadly applied to other client cohorts with chronic conditions and can be applied across other metropolitan and rural areas, subject to a satisfactory evaluation of the model outcomes.

This report outlines issues identified in the current state, a detailed description of the key model elements that are intended to address the identified issues, a guide to the vital supporting system-level activities and structures required to support the model, and practical implementation strategies.

1.3. APPROACH

Aspex Consulting undertook the following steps to inform the development of the service model:

- Completed a **literature scan** to identify existing service models of integrated care and other models of 'out-of-hospital' care that combine health and social support services;
- **Consulted** with the organisations on the Yarra Ranges Round Table to understand current issues, barriers and opportunities and any critical elements of a future model (Refer Appendix A1);
- Identified **existing providers** of youth mental health, together with wrap-around social services in the Yarra Ranges, to understand the current service system; and
- Reviewed relevant **grey literature** pertaining to the project, including the Victorian Auditor General's Office (VAGO) recent audit into Child and Youth Mental Health, as well as several submissions made to both the current Productivity Commission's Inquiry into The Social and Economic Benefits of Improving Mental Health and the Royal Commission into Mental Health.

A more detailed description and analysis of the abovementioned approach has been provided in an accompanying report: *Integrated Health & Social Services Response – Youth Mental Health: Background Report*.

1.4. GUIDING PRINCIPLES

Four core principles were developed by the PWG to underpin the framework for the service model:

1. **Integration** - coordinated and seamless services, *within and between* providers. Key enablers include funding flexibility, and client-level information sharing.
2. **Effectiveness** - community value and the greatest *client benefit* (supported by measurable outputs and outcomes).
3. **Local Governance -** the capability of participating service providers *to jointly plan, and develop* mechanisms that enable greater clinical governance, transparency, and clear accountability for quality, distribution and value of services delivered.
4. **Sustainability** - through the system's design, configuration and critical mass, including a high level of flexibility, adaptability and capability *to be innovative and evolve over time*.

The service model demonstrates adherence to each of the principles.

2. The case for change

The need for a new model of service delivery becomes clear when issues in the current system are considered. The main issues include:

Access and referral pathways – many young people and their families are unsure of where to access an appropriate service. This is described by all stakeholders as a major impediment to early and/or appropriate access. For those who do access a service, they often have trouble navigating lengthy and confusing referral processes.

Service integration and seamless care - discontinuity between disability, primary and acute mental health care and social services is a significant structural weakness, and many people at high risk of poor mental health outcomes continue to 'fall through the cracks'.

Service gaps - there are a number of service gaps within the system, including a lack of suitable community mental health and connected social support options, adequate services for those young people with moderate mental illness (the missing middle) and inadequate capacity for those requiring specialist assessment and treatment (the missing severe). This is further compounded by the siloed nature of health-related services from the integrally linked social supports required for this cohort.

Priority populations - the current system does not adequately target or respond to the demand for services by priority populations, including those involved with youth justice or protective services, those in rural and remote areas and ATSI, CALD or the LGBTIQ+ community.

Prevention and early intervention – a lack of capability in 'front-line' health and social service providers to recognise underlying determinants and triggers for psychological distress and being able to provide appropriate early intervention in mental health or psychosocial support that could forestall escalation of mental health issues.

Funding arrangements – are currently activity, episode or entity-based, which reinforces siloed practice and does not support a multidisciplinary, multi-sector service model focused on holistic client outcomes.

Workforce - there is a shortage of appropriately skilled workers who have the capability to effectively and appropriately engage with young people experiencing mental health issues. This includes an acknowledged paucity of peer-support workers, youth workers and disability workers.

Data collection and outcome measurement – there is a lack of data to support demand assessments based on need and outcome measurement is in its infancy. This is particularly salient for local government members of the EMP who are required to ensure examination of data about health status and determinants in the municipal districts as part of the mandated requirements under Section 26 of the *Victoria's Public Health and Wellbeing Act 2008.*

Governance and accountability – performance monitoring of child and youth mental health and social services currently comprises several separate systems that do not coordinate or share information with one another. Furthermore, there is no strategic governance framework to guide and coordinate services.

The integrated service delivery model has been designed with the intention to of addressing these widely known and acknowledged issues that exist within the current service system.

Furthermore, the model seeks to anticipate and respond to potential outcomes from the current Royal Commission into Mental Health Services in Victoria. In particular, the second term of reference which seeks to discern, amongst other matters:

"How to deliver best mental health outcomes and improve service access to and the navigation of Victoria's mental health system for people of all ages, including through:

- *Best practice treatment and care models that are safe and person-centred; ……..*
- *Strengthened pathways and interfaces between Victoria's mental health system and other services;*
- *Better services and infrastructure planning, governance, accountability, funding, commissioning and information sharing arrangements; and*
- *Improved data collection and research strategies to advance continuity of care and monitor the impact of any reforms."*

3. Service model framework

The integrated service delivery model has been designed around the individual's needs (person-centric), and not the needs of service providers (system driven). The model is holistic and can be tailored to an individuals' health and well-being, family and social support needs, self-management ability, preferences including how he/she accesses services, and the environment within which they live. This includes consideration of:

- Preferences such as religion, culture, ethnicity, language, sexual identity, socioeconomic position, educational background and whether they require individual, group, face-to-face or online services;
- Co-existing health conditions and social issues;
- Life experience, including any trauma history; and
- Relationships and connectivity with family, friends, coaches, teachers, etc. and the potential of those people to play a formal and informal carer/mentor role.

The model does not necessarily present new concepts and may not include significantly different services than currently available; however, the way in which the model will be implemented ***presents a new way of working and delivering care in the Yarra Ranges****.*

The overarching integrated service model framework is comprised of three levels:

- Level 1 – Integrated services providing tailored services directly to clients and their families/carers.

  The first level of the service model relates to the core functional design and integration of direct client and family/carer services. All of these services are person-centred, holistic and integrated to meet the assessed needs of individuals and their families/carers. They need to include the full range of health and social support services that comprise holistic, person-centred care.
- Level 2 - Area-based Services.

  The second level of the model relates to direct services and seeks to adopt a population health paradigm that are not targeted at an individual client or family. Instead, these services are intended to focus on reaching the broader local population for awareness and 'at risk' cohorts within the population for mental ill-health prevention and early intervention. They need to address the underlying social and health determinants that contribute to both mental and physical well-being.
- Level 3 - System structure, support mechanisms and governance.

  The third level is essential for the service model to operate effectively. It includes the supporting architecture of the service system within which the integrated service delivery model needs to operate.

Together, Levels 1 and 2 form the core integrated service model supported by Level 3, the system level services.

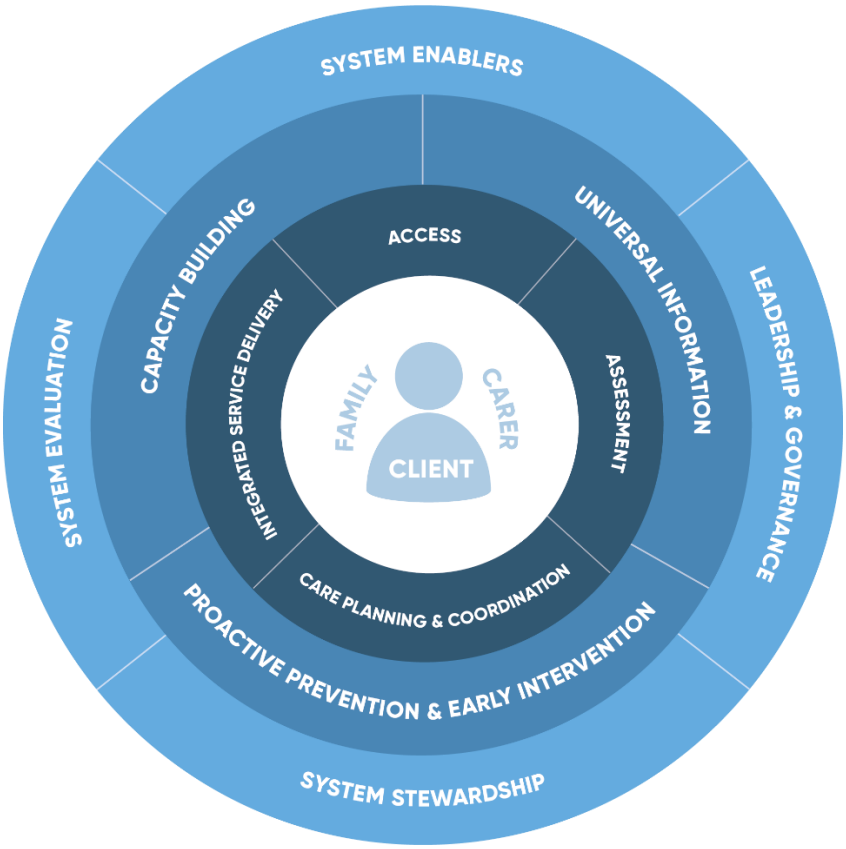
An important feature of the model is that its composition is function-based, or a tailored service, rather than funding-based or program-based. A function-based model is considered superior as it best enables a stepped care, client-focused and integrated approach.

The integrated service model incorporates clinical mental health services across the spectrum from mild through complex mental health conditions, physical health services and social support services.

From herein this spectrum of services (providers) are referred to, in combination, as engaged entities.

Figure 3-1 provides a depiction of the integrated service model framework, after which each element of the model is described.

Figure 3-1: Integrated Service Model Framework



4. Tailored and holistic (Level 1)

Definition: Level 1 services are direct, integrated client and family/carer services that are tailored to meet the holistic needs of individual clients, and/or their families/carers.

Direct services or service functions have been clustered into four elements that are typical of a client journey:

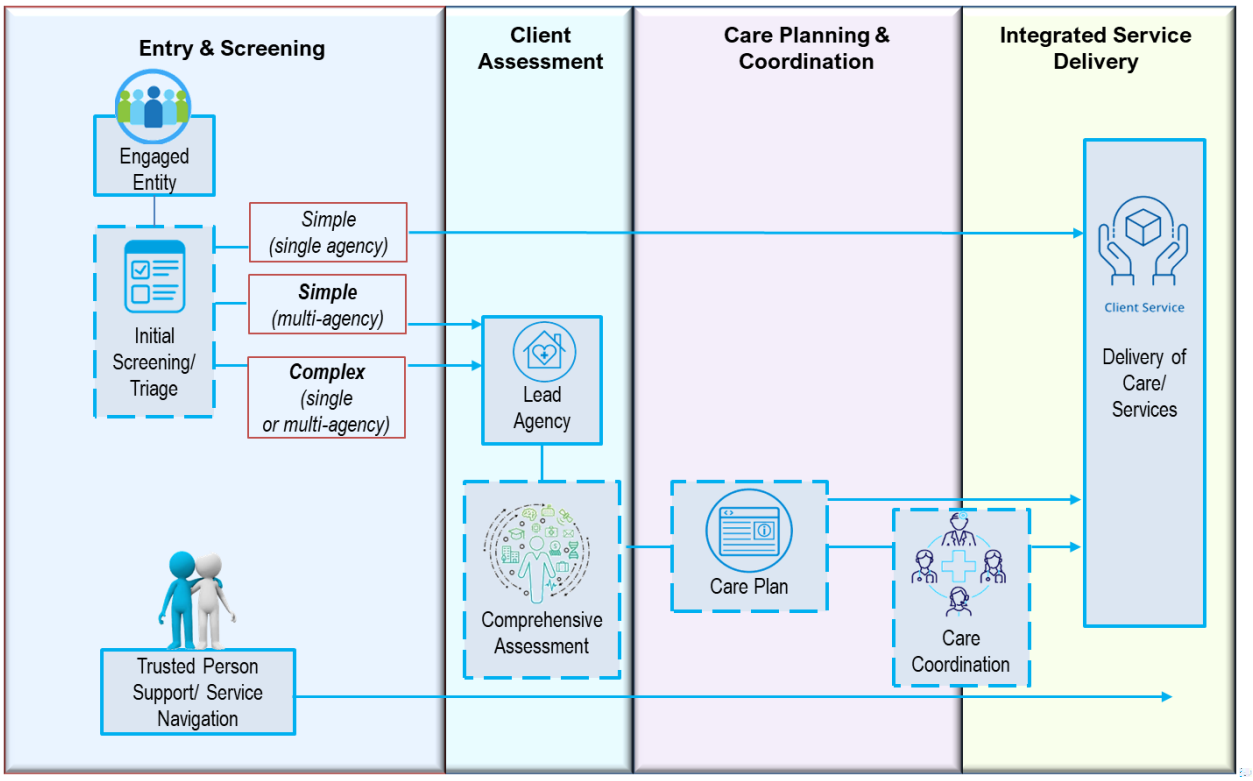
1. **Access** – incorporating entry and initial triage;
2. (Comprehensive) Client **assessment**;
3. **Care planning and coordination**; and
4. **Integrated service delivery**.

This is shown in Figure 4-1.

Figure 4-1: Level 1 - Tailored and Holistic Services

Figure 4-2 provides an overview of the direct service elements in Level 1 typical of a client pathway and these are described below.

Figure 4-2: Level 1 direct client and family/carer services



4.1. ACCESS

One of the main weaknesses of the current service model is the demonstrative lack of client awareness of, and access to, available services, including an inability and confusion of clients, family/carers to know what to do, or where to go for help, with emerging or manifesting mental health issues. This includes potential social support services that may act as circuit breakers in catalysts for further exacerbation of emerging problems. For example, assistance relating to family violence issues, homelessness or other health or social determinants that contribute to mental health issues.

Enabling easier access to services is the principal reason for having such a strong focus on the 'front end' of the model.

4.1.1. Entry and screening

Entry is the 'first contact' by the client or family/carer. It may be the only contact, or the first of a longer client journey.

The principle underpinning entry and screening is a '*No Wrong Door*' philosophy. This approach underpins both the Australian and Victorian governments health and social policy for services supporting people with co-existing problems, in particular putting "young people at the heart of service delivery"[1] In effect, whenever a young person presents with an identified need, within the service or school system, they need to be supported to find the help they require and not be turned

1. It is noted that most current service providers are signatories to the local government initiative *No Wrong Door* youth partnerships in the Outer East.- http://www.nowrongdoor.com.au/var/files/uploads/pdfs/9428cd5137a7682151ba6d4e882f3f75.pdf

away or delayed. This means *every participating entity should be the right door, notwithstanding the client's needs*.

Additionally, the concept of *No Wrong Door* offers an enhanced 'wayfinding' approach to better enable young people to be directed to the appropriate service[2].

The initial screening ideally occurs at the time of an initial contact with an engaged entity. In essence, it constitutes a triaging of the initial (indicative or prima facie) client needs; and risk.

However, this does not mean that it is the first time the client and their family/carer is seeking a service from the particular engaged entity.

How the entity proceeds following initial screening will be unique to each client and their family/carer, which is fundamental to person-centric care. However, there are two broad options that could apply from this stage forward:

1. **Simple (single entity)**: the entity determines that the client's needs can be met within their range of service offerings, **and** within their scope of practice; or

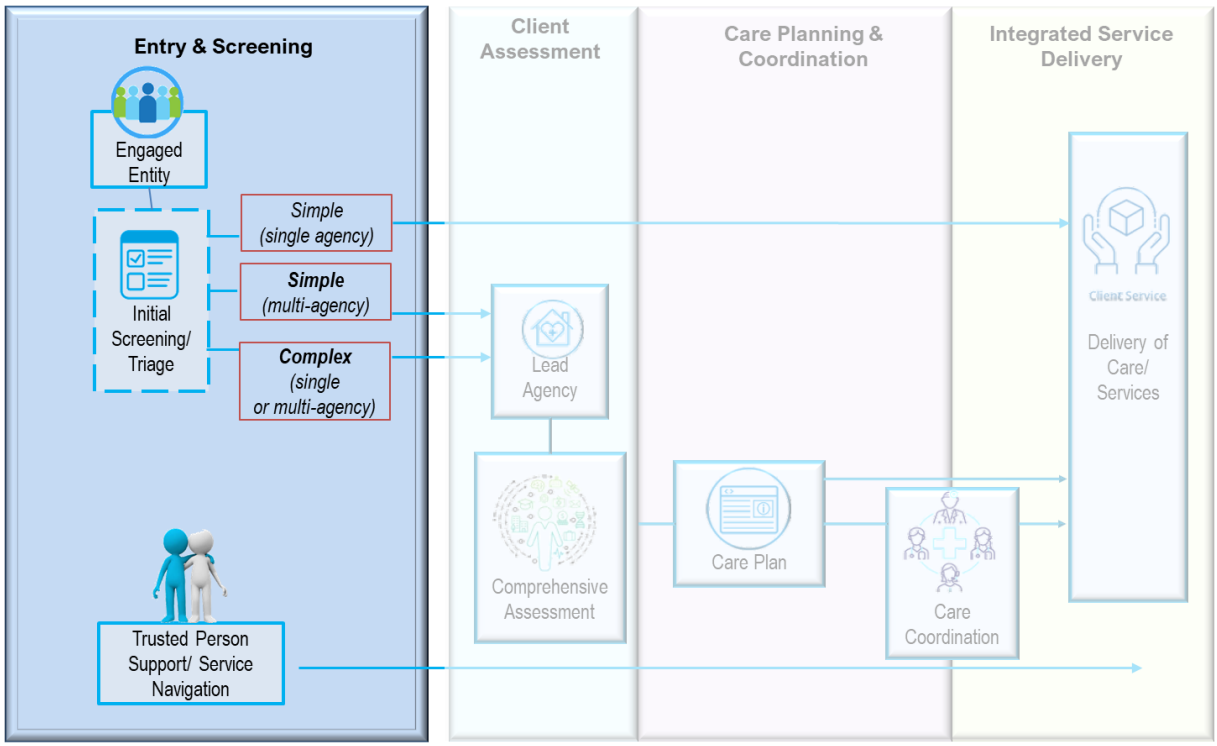
   Simple (multi-entity): the entity determines that the client requires additional or alternative service and makes a seamless referral (preferably a 'warm referral'). Consistent with the stepped care model, referral could be to a higher or lower acuity/complexity service, including referral to an emergency service; or
2. **Complex (single or multi-entity)**: The entity determines that the client's needs are complex, or require complex assessment, or require multiple mental health, health and social support "wrap-around" services (one of which may be their own). In this case, the entity can:
   a. ***Adopt a 'lead entity' role*** and proceed to undertake a comprehensive assessment (see section 4.1.2).; or
   b. ***Adopt a support entity role*** and transfer the client and their family/carer to a designated lead entity for a comprehensive assessment; or
   c. Refer the client and have no further part in the client's assessment.

It is important to clearly differentiate the roles of the lead entity in undertaking the comprehensive assessment and care coordination from the role of client liaison with a person who may have developed a trusting relationship and rapport with the client.

This part of the model is acknowledged to be reactive in that it responds to approaches to existing providers. The model also has proactive elements that makes the broader community aware of services, and target 'at risk' groups who may need to recognise signs and symptoms of mental health conditions (See sections 5.1 to 5.3).

[2] The No Wrong Door approach is an improved 'wayfinding' model. It is different to other initiatives such as the Orange Door Initiative for family violence, which delivers definitive care and support.

Figure 4-3: Entry and Screening



Requirements for effective implementation - entry & screening

- The proposed Strategic Agreement requires all participating entities to accept 'first contacts' and fulfil the requirements of a 'no wrong door' philosophy and encourage 'warm referrals' and connection with the most appropriate service provider to undertake a comprehensive assessment.
- Comply with the proposed Operational Protocols Agreement, that would require:
  - Collecting agreed minimum data from the client/family/carer and enter onto a 'first contact' register.
  - Undertaking initial screening (triage).
  - Refer appropriate clients to a lead entity for comprehensive assessment, care planning and coordination, if it is not within their clinical capability and/or they do not have capacity to perform this function.
- Foster or facilitate a 'trusted person' to be engaged where required. (This role includes having a genuine rapport with the client/family and work with a client or family/carer until their needs have been met by their own entity or by an alternative entity).
- Develop a standardised initial screening tool – *at minimum, entities need to be completing a standardised component* of an initial screening, which would include (or may build upon the *Initial Needs and Referral Tool* currently available on the 'No Wrong Door' website).
- Support a centralised data repository of all initial contacts, including all initial screening reports for data sharing between entities (more detail section in 6.3.3.).
- Develop online navigation tool for client/families/carers – the current 'No Wrong Door' online youth service directory for youth could be further developed and leveraged.
- Support an online navigation tool for engaged entities – HealthPathways could be leveraged and potentially linked to the 'No Wrong Door' online youth service directory.
- A physical presence and hub service navigation role could be developed – i.e. co-located with other health and social service providers.

4.1.2. Assessment

Complex clients and their families/carers will require a comprehensive needs assessment. This assessment will inform a client-centred service plan; whether formal or informal (and the subsequent mobilisation of services delivered by one or more entities).

The needs assessment is likely to engage the client (and family) to participate in the assessment of need, as well as require a multi-provider assessment of clinical and social support needs for most clients.

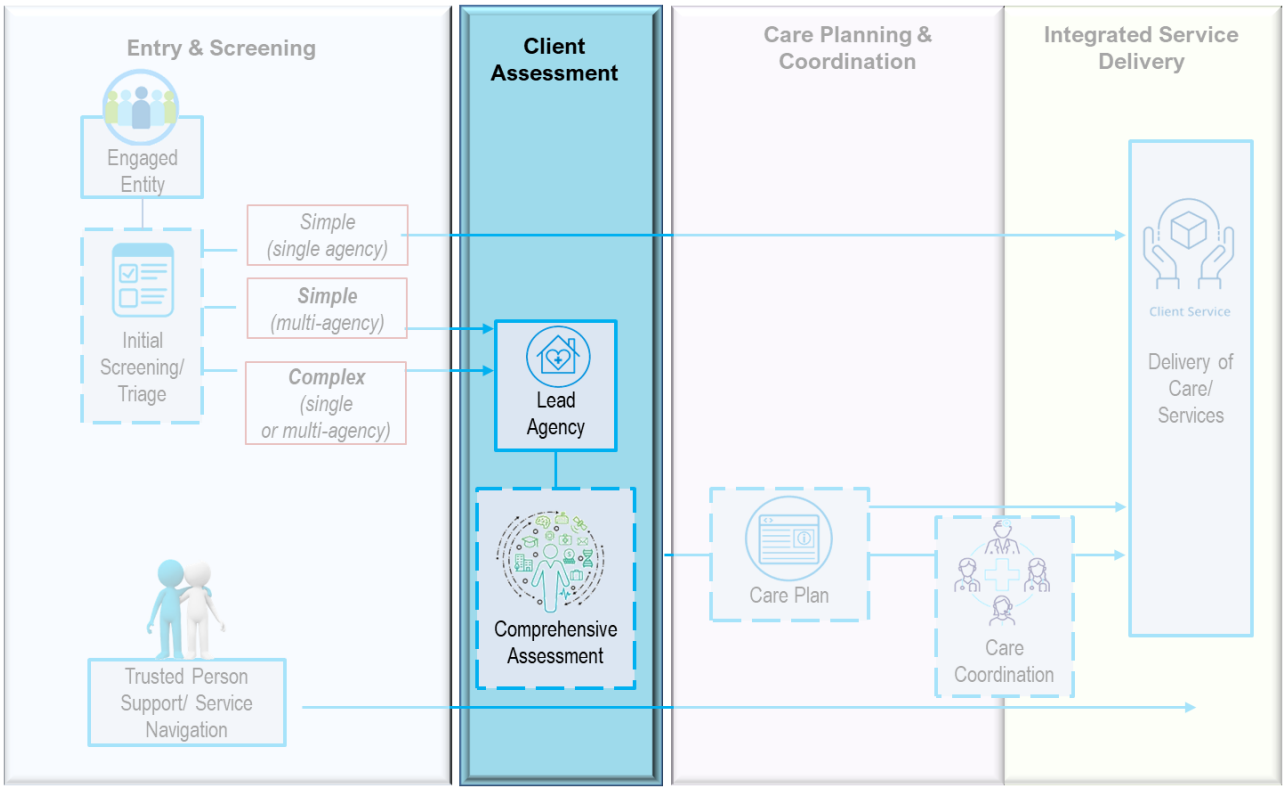
The determination of the lead entity responsible for assessment and care coordination would be determined early, preferably on referral.

It is generally expected that the (agreed) lead entity would be:

- Providing/coordinating the comprehensive assessment;
- Responsible for care coordination; and
- Oversight of ensuring that the care plan is being delivered; whether for clients with straightforward or complex needs. However, this will not always be the case by agreement with the parties.

To ensure that clients are not 'lost' due to a failure to agree on lead entity status, a default lead entity (or entities) may be nominated in the Operational Protocols Agreement.

Figure 4-4: Assessment



It is expected that the trusted person would remain involved with the client, family and service providers where this benefits the client.

All entities who participate in the service model would be required to contribute to the design and implementation of a standardised comprehensive assessment tool and will likely build upon the initial screening tool discussed in section 4.1.

It is important to stress that the assessment tool may not replace pre-existing entity-specific assessment tools required for clinical or quality purposes. However, there would be common elements either in summary form, or 'bolt-on' form to existing assessment tools.

The agreed common validated assessment tool would reflect best practice in youth mental health assessment and determine the client's mental health condition, other clinical health, and social support needs consistent with a stepped care service model relating to complexity.

The agreed assessment tool is most likely to include a validated tool to determine the client's and their families/carer's ability to self-manage their care/supports, such as the Patient Activation Measure (PAM). Self-management abilities play an important role in integrated care. An individual's self-management abilities are especially relevant when they need to deal with multiple problems and providers that may work in different sectors, simultaneously.

Although the outcome of the assessment will be unique to each client, it is likely that the majority of clients and their families/carers will fit within the existing stepped care model and PAM score range.

The standardised comprehensive assessment tool would become subject to periodic evaluation.

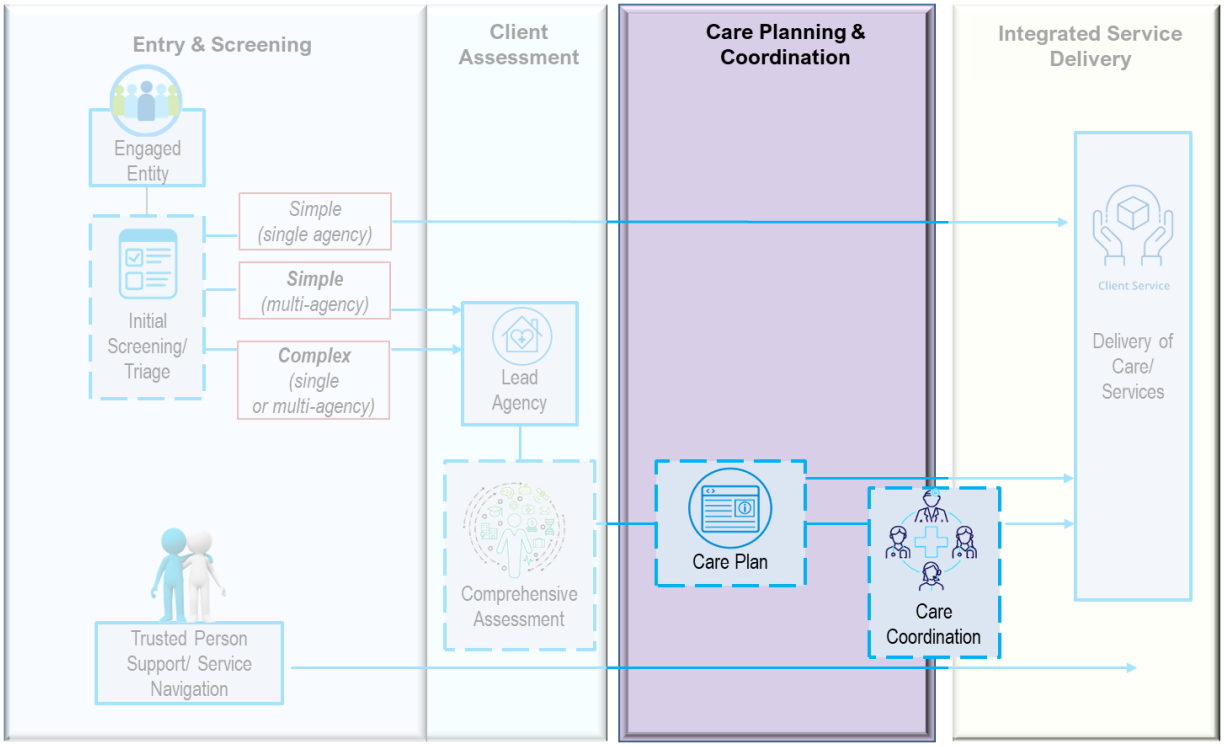
Requirements for effective implementation - comprehensive assessment

- Identify a lead entity (as previously noted).
- Identify the key client care coordinator (if required).
- Develop a client assessment register.
- Develop a lead entity service capacity and current service capacity monitor, which could include client waiting times and related access data on a commonly shared secure website.
- Develop and commit to a comprehensive assessment tool (as a summary or a bolt-on to existing assessment tools at some entities) and adoption of the PAM-type tool.
- Establish assessment tool performance metrics.
- Develop a centralised data repository – all comprehensive assessments to be submitted to the centralised repository for data sharing between entities (more detail section in 6.3.3.).
- Undertake regular audit and evaluation of the data repository to ensure quality and timeliness of data entry.

4.2. CARE PLANNING AND COORDINATION

Following a comprehensive assessment, all clients and their families/carers will be eligible for a (multi-entity) service provider care plan. Similarly, there will be an entity responsible for the execution of the care plan. Generally, this would be the lead entity.

Figure 4-5: Care planning and coordination



Multi-provider care plan

Multi-provider care plans would be based on a common, electronic template. It is expected that there would be core mandatory fields, with capability for an entity to add other non-core elements that are specific to that entity.

Mechanisms would be in-place to allow the lead entity to change over the course of the client's care path.

In addressing the needs of young people with mental health concerns, engaged entities should be cognisant of the Chief Psychiatrist's guideline on *Working together with families and carers,* which requires that whilst the client remains the focus of care, if the client agrees, families/carers may be involved in planning treatment and care.[3] Shared decision-making is an essential part of integrated care, and entails discussing goals and options to achieve these, identifying and clarifying issues and possible solutions, and ensuring that all involved persons understand each other.

Planning may include agreed goals and treatments, services, timelines, responsibilities, and follow-up to review progress. Plans can also be used to reassess and adjust goals, ensure continuity of care, and act as a communication tool between providers and clients.

Specific measures that proactively support the *safety and wellbeing of clients assessed as being at significant risk* need to be incorporated into the plan. These measures may include regular monitoring of the client's circumstances to determine if a reassessment of the need for emergency or crisis intervention is required (for example, to account for increased risk from a perpetrator of family violence).

All plans would be uploaded to a central repository and made available to all other engaged entities.

3. Department of Health and Human Services, Working together with families and carers - Chief Psychiatrist's guideline, August 2018

A common issue is the potential for clients to have to 'tell their story' multiple times. The lead entity responsible for the coordination of multiple services would assist to minimise or avoid this happening as much as practically possible. The sharing of the comprehensive assessment and care plan through the centralised data repository would also serve to mitigate against the need for retelling the client story.

Care coordination and support

The comprehensive assessment and care plan would reflect best practice and determine the client's mental health, other physical related clinical health and social support needs along the stepped care service continuum, and the client's self-management ability.

The level of ongoing coordination and support the client and their family/carer receives from the lead entity will be tailored to suit the client's complexity and ability to self-manage their care plan. There are tools (such as the PAM tool) that could be used to assess how capable the client and their family/carer is at self-managing their condition(s) and progressing their care plan.

For example, if a client has the knowledge, willingness and confidence to manage his/her particular condition, care coordination may be as basic as electronic resources and support. This may focus on prevention for those with mild to moderate mental health issues or physical health conditions, and condition management for those with severe mental or physical health issues.

For those that do not have the knowledge, are disengaged or overwhelmed, more intensive care coordination would occur, from a named care coordinator. This named coordinator would be based within the lead agency and would help coordinate care for the client across the service continuum, for as long as the client requires.

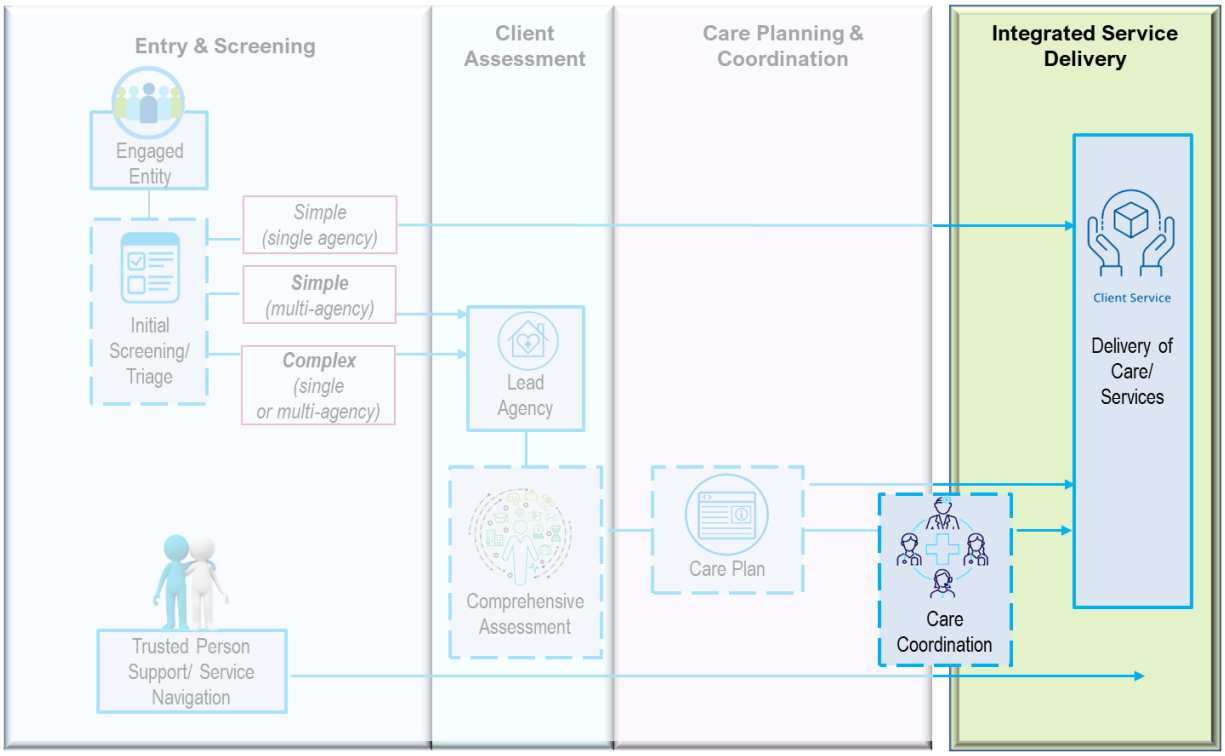
Requirements for effective implementation - care planning and coordination

- Develop a common multi-provider care plan template.
- Develop a centralised data repository – all care plans to be submitted to the centralised repository for data sharing between entities (more detail section in 6.3.3.).
- Care Plans should detail existing factors that may compromise the client's safety and wellbeing (client history, illness/problem trajectory, family and living situation).
- Care Plans should present all 'red flags' (both clinical - e.g. flags to identify regression of illness, and non-clinical - e.g. flags to identify an unsafe home environment).
- Emergency action and response plans should be developed, to include appropriate emergency intervention, referral, emergency contact numbers and safe locations, and invoked when 'red flags' are identified.
- Clients and care plans should be continuously monitored and reviewed.
- Establish communication protocols, procedures and systems.
- Undertake workforce review to identify the ideal workforce model to support care coordination.
- Develop an accountability protocol – lead entity responsible for client outcomes.
- Develop mechanisms to transfer lead entity if needed.
- Implement a client/user feedback system to gauge the effectiveness of the care coordination and support services.
- Ensure lead agencies participate in periodic refresher courses, workshops and that the resource toolkit is regularly updated.
- Ensure that 'consent to share' client information between all providers is acquired from the client and family/carer at the time of the multi-provider care plan development.
- Undertake evaluation of the multi-provider care plan and coordination role.

4.3. INTEGRATED SERVICE DELIVERY

All clients and their families/carers would receive integrated service delivery, irrespective of whether they undertook a comprehensive assessment.

Figure 4-6: Integrated service delivery

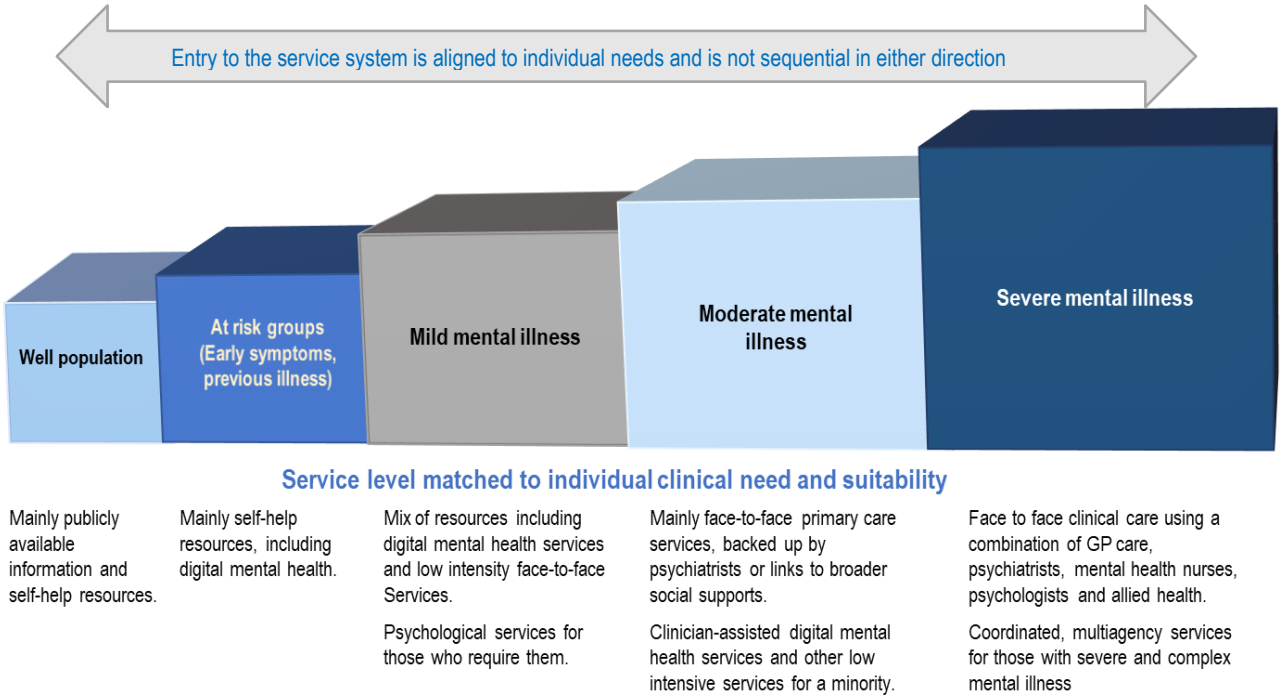


Integrated service delivery can be achieved within the context of, and potentially the expansion of, the existing Mental Health Stepped Care Model within the Eastern Melbourne Primary Healthcare Network (EMPHN) and through consistent application of the *No Wrong Door* philosophy as it applies to the breadth of health and social support services to which entities in the Outer East are party.

In addressing mental health services within the stepped care approach, a person presenting to the mental health system is matched to the necessary intervention level that most suits their current need (Figure 4-7). An individual does not generally start at the lowest, least intensive level of intervention in order to progress to the next step. Rather, clients enter the system and have their service level aligned to their requirements. Despite the multiple levels within the stepped care approach, each level should not operate as a one directional step, but rather offer an integrated spectrum of service interventions.

Importantly, consistent with the holistic care contemplated by this innovative service delivery framework, the stepped care model considers the whole person and addresses other needs including physical health, education and employment, alcohol and other drug harm reduction, family and social functioning, and suicide and self-harm reduction.

Figure 4-7: A stepped care approach to mental health services



Emphasising collaborative care, the model involves the consumer's General Practitioner (GP), care team and significant other services when appropriate. Services can be delivered by psychologists, social workers, occupational therapists, credentialed mental health nurses and peer workers. Support is provided through:

- Directing people to self-help resources and support services;
- Online, eHealth technology and apps;
- Face-to-face support in group or individual interventions;
- Care coordination;
- Medication and psychiatric review; and
- Secondary and tertiary mental health.

The types of services that currently, or potentially, could form part of the stepped care model in the Yarra Ranges are described below. The identified service elements are not intended to be exhaustive as it is recognised that they do not represent all possible services that could be available to the client cohort.

4.3.1. Acute and specialised care

Acute and specialised services include the core of the formal clinical mental health services for youth. In the Yarra Ranges, these are delivered by Eastern Health and include clinical mental health services that are identified as Tier 3 services in the *SAFE Minds System of Care Map*.[4] Specifically, the Child and Youth Mental Health Service (CYMHS) includes consultation and assessment, community clinical case management, therapeutic interventions and acute psychiatric inpatient care for children and young people up to the age of 24. Intake to CYMHS is via the Eastern Health Access team, or a psychiatric triage clinician for after- hours emergencies, or on weekends.

4. SAFEMinds is a collaboration between headspace and the State Government of Victoria. Available: http://deecd.tech-savvy.com.au/pluginfile.php/3973/mod_resource/content/10/SAFEMinds%20System%20of%20Care%20Map%20%28VIC%29.pdf

It will be important for the operational effectiveness of the model that the acute services are responsive.

4.3.2. Community maintenance and recovery

There are infinite levels of maintenance and recovery from intensive support to occasional support. The nature of the support will also vary from highly specialised mental health professionals to volunteer support workers.

The more complex end of the spectrum requires intensive support of skilled mental health professions as a substitution for acute beds, and post-discharge from an acute bed. Eastern Health's CYMHS provides community clinical case management and therapeutic interventions and operates the Youth Engagement and Treatment Team (YETTI) as an outreach service. YETTI provides care for those aged 12-25 years who do not meet the criteria for tertiary mental health care but whose needs are greater than can be provided by primary health. This cohort is often referred to as the 'missing middle'.

The clinical capacity of this service will be critical to the success of the service model.

4.3.3. Step-up / step-down residential care

There is no prescriptive residential model that is proposed for this service model. Nevertheless, an existing system model is the Prevention and Recovery Care (PARC) service.

PARC is a community based short-term, recovery focused, residential service for people who are either leaving acute mental health care or would benefit from 24-hour support to avoid a hospital admission. There is no youth-specific PARC (Y-PARC) service in the eastern suburbs. However, Y-PARC services have the potential to play an increasingly important role in the nexus between acute and community-based services in the outer east in the expectation that there is sufficient demand (of approximately 8-12 beds) to ensure sustainability.

This integrated service model may examine the relative merits in the area, relative to other youth mental health services. This would be typically delivered as a Y-PARC or Y-PARC-like service, by a specific community mental health support service provider with direct access and clinical support from Eastern Health. There are models where the PARC service is directly operated by the designated area mental health provider (i.e. Eastern Health).

4.3.4. Primary health care

This is a critical element to the model. Given the extensive evidence of the poorer physical health outcomes experienced by people with a lived experience of mental illness (and substance misuse) it is essential that young people, particularly those 'at-risk' have access to consistent primary health care services. Indeed, the first principle of the *Equally Well Consensus Statement: improving the physical health and wellbeing of people living with mental illness in Australia,* speaks to "a holistic, person-centred approach to physical and mental health and wellbeing"[5].

In most instances, primary care is the starting point for this holistic care. It may be a predominant part of the services for some clients, and marginal for other clients. However, in almost all instances, primary health care should form part of the assessment and delivery of a holistic service. Conversely, there is a need for primary care providers to incorporate a mental health response as a core component of their work, which is synergistic with holistic physical health care. The stepped care model encourages collaboration of a client's GP with other health and social service providers.

5. National Mental Health Commission, Equally Well Consensus Statement: improving the physical health and wellbeing of people living with mental illness in Australia, July 2017

4.3.5. High interface services and priority populations

Some clients may require specific service development and/or integration in the stepped care model, including:

- Youth Justice clients;
- National Disability Insurance Scheme (NDIS) clients;
- Youth under Child Protection Services;
- Dual diagnosis clients (mental health problems and problematic drug and alcohol use);
- Youth LGBTQI+ clients;
- Aboriginal clients; and
- Culturally and Linguistically Diverse (CALD) clients.

The extent to which the stepped care model currently operating within the EMPHN meets the needs of youths within these client groups may need to be reviewed and enhanced.

It is expected that the engagement of each 'high interface' group will take time. Not all interface groups will be able to respond consistent with the principles of the model. Hight priority interface areas should be targeted.

4.3.6. Family / carer support

People caring for a young person with mental health needs will also need information and support as this role can be a stressful and traumatic experience. The basic information and support that may help parents and carers includes:

- A named point of contact (who may be a care coordinator or an individual practitioner), and/or a named service system navigator;
- Protected time to talk to providers about the client's care, at a time that accommodates working patterns;
- Information about any treatment, admission or support service for the client;
- Assistance with preparation of a crisis plan – what they can do and who they can contact if the person they are caring for requires emergency assistance; and
- Help with personal coping strategies and promotion of their own health and wellbeing.

4.3.7. Social inclusion and reintegration

A holistic service delivery model must have social inclusion and community integration components. Again, these will vary with individual need. Typical of these needs are:

- Housing/accommodation services;
- Education and learning (particularly important for the age of the cohort);
- Employment and vocational services;
- Family / domestic violence services;
- Culturally inclusive services;
- Social and daily living skills;
- Social inclusion activities;
- Personal development activities; and
- Behaviour change and addiction modification activities.

Requirements for effective implementation - integrated service delivery

- Develop and strengthen models of care that serve to integrate primary care, mental health and social support services.
- Extend the existing stepped care model beyond the health sector to incorporate the full range of health and social support services, including high-interface services and priority populations.
- Develop a network of social support services that integrate with clinical services in the catchment.
- Develop capacity to deliver social support services to meet expressed demand.
- Confirm the stepped care model is appropriate for young people (aged 12 to 25).
- Include clear and explicit criteria for the thresholds determining access to, and movement between, the different parts of the pathway.
- Ensure clients and their families/carers are receiving care that is matched to their needs and ensure timely access across the spectrum of care.
- Provide the least intrusive, most effective intervention first.
- Desist from using single criteria such as symptom severity to determine movement between steps.
- Monitor progress and outcomes to ensure the most effective interventions are delivered and the client moves to a higher step if needed.
- Establish clear links (including access and entry points) to other care pathways (including those for physical health care and social reintegration needs) whether this be '*up', 'down' or 'across'* to the appropriate health and/or social service.
- Minimise the need for transition between different services or providers.
- Facilitate services to be built around the pathway and not the pathway around the services.

Level 1 of the integrated service delivery model addresses current issues with access and referral pathways, service integration, service gaps and the needs of priority populations.

Level 1 services demand high levels of collaboration between service providers.

5. Area-based services (Level 2)

Definition: Specific youth non-clinical and social support services within the catchment that are not tailored or targeted at individual clients or their families/carers.

If Level 2 is considered within the context of the stepped care model, area-based services cater to the general (well) population, as well as groups who are 'at risk' (e.g. those with early symptoms or a previous illness). If looked through a population health lens, this level is focused on primary prevention. Level 2 also aims to build the capacity and capability of providers within the system to detect and refer 'at risk' youth before symptoms/conditions deteriorate.

Level 2 services have been grouped into the following elements to reflect their target audience and degree of specificity, as shown in Figure 5-1:

- Universal information;
- Proactive prevention and early intervention; and
- Capacity building.

Figure 5-1: Level 2 – Area-based services

5.1. UNIVERSAL INFORMATION

Universal information is publicly available information that covers a description of mental and physical health conditions, treatment information, local service types and locations, how to access or refer to a service, where to get help, etc.

It also includes information on other (complementary) services that young people, in particular those with mental health needs may be interested in, including physical health, education, employment assistance, housing, drug and alcohol services, family counselling, legal matters, relationships and sex, gender identity, bullying, etc.

It is advisable that the creation of information and its dissemination is included as part of a pilot program.

Requirements for effective implementation – universal information

- Provide service and access information to the general public via their own webpage.
- Provide useful links on the webpages for other local, complementary services.
- Contribute to the development of a comprehensive, centralised online resource contains information for all engaged entities and includes a service directory or navigation tool (the current No Wrong Door website, or future iterations of this website), may provide a good starting point.
- Ensure engaged entities provide a link to the centralised online resource through their own webpage.

5.2. PROACTIVE PREVENTION & EARLY INTERVENTION

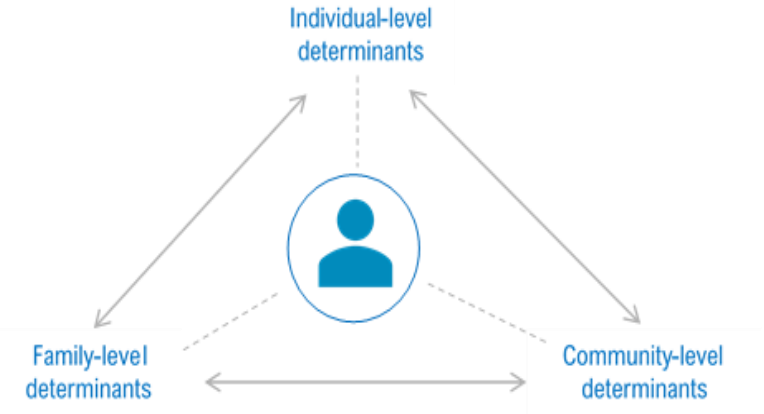
Proactive prevention and early intervention services are targeted to 'at risk' groups and refers to services that inform and educate, support the modification of behaviour, and facilitate early intervention in 'at risk' situations.

This element goes a step beyond universal information by actively seeking out settings where at risk youths frequent, such as schools, sporting clubs, 'arcades', Neighbourhood Houses, GP clinics and Youth Justice, among others.

Proactive prevention and early intervention seek to recognise and address the potential determinants of mental wellbeing through promoting positive or protective factors and ameliorating potential risk factors. Both risk and protective factors (determinants) exist at the individual, family and community levels (Figure 5-2). The challenge for holistic or integrated services is being able to:

- Remediate consequences of adversity and vulnerabilities in early years;
- Prevent exacerbation through preventing progression of distress or dealing with behaviours that compound mental health conditions, for example substance misuse or offending;
- Break the intergenerational transmission of violence, abuse, trauma or inequalities of poverty from adults to their children; and
- Attend to the physical health needs of young people with mental illness.

Figure 5-2: Determinants of mental health



Proactive measures would be undertaken by health professionals who can provide information, tools and resources, and support teachers, coaches and other professionals engaging with 'at risk' populations or responding to requests.

Early intervention may include assessing behaviour (influences, triggers), talking to the young person about their behaviour, developing a behaviour support plan (addressing substance misuse), collecting data to inform any decision-making process, making any necessary environmental changes (such as changing classrooms), teaching of replacement behaviour and engaging support services.

Requirements for effective implementation – proactive prevention and early intervention

- Identify community settings supporting 'at risk' clients within the Yarra Ranges.
- Ensure a designated entity or agencies within the Yarra Ranges collaborate to deliver programs to those organisations or groups supporting 'at risk' youth.
- More comprehensive education provided to front line organisations to enable them to identify 'red flags'.
- Standardised identification 'check-list' for front-line organisations to be utilised following identification of a 'red flag'. This tool would aid the organisation to decide whether a comprehensive assessment is required.
- Establish an inter-entity working group to address intersectoral issues which have an impact on 'at risk' youth including Youth Justice, Child Protection Services, Housing, Educational amongst others.

5.3. CAPACITY BUILDING

This Level 2 element of the service delivery model is intended to build the capacity of:

- Professionals such as teachers and coaches who work with young people to recognise signs and symptoms; and
- With professional health providers who are not necessarily specialist mental health professionals. This includes the staff of all engaged entities and individual providers working within the region.

The intention is multifaceted. Firstly, it is to build awareness of the integrated service delivery model (incorporating the stepped care approach) so that the purpose, breadth, capability, capacity and integrated nature of the model is well understood.

Secondly, health professionals require a specific skillset to deliver care that is integrated. Different capabilities are required across all aspects of the integration of care from program design and management, through to the delivery of health and social care and the measurement of outcomes associated with the integration of care.

Thirdly, to inform and educate all staff and individual providers on the existence, role and clinical (or other) capability of all engaged entities to support appropriate and seamless referrals.

Requirements for effective implementation – capacity building

- Develop a, multi-faceted communication plan for providers;
- Provide an opportunity for staff at the coalface to input to co-design of the service model and the practicalities of working collaboratively;
- Allocate time and resources a during the implementation phase to educate engaged entities and allow for relationships to be built;
- Require local integrated care forums to be conducted by health organisations and services to transfer and scale up care integration in a changing environment;
- Develop capability to measure client outcomes and experience through case-based learning opportunities and cross sector (health and social care sectors) training programs; and
- Facilitate opportunities for providers to engage in redesign, project management and change management activities in the context of integrated care.
- Provide face-to-face training and education sessions to staff, coaches, students, parents and carers on-site in schools and other identified settings.
- Provide, and regularly refresh, resource toolkits, including standardised assessments, checklists, prevention strategies, etc. to the identified settings.

Level 2 of the integrated service delivery model addresses current issues with information that can directly impact on early detection/intervention, access and referral pathways and service integration.

6. System structure and support mechanisms (Level 3)

Definition: System services that support the effective delivery of integrated health and social services for young people with mental health needs. These services are not client specific and are not provider specific but provide the foundational structures for efficient service delivery.

Implementation of the integrated service delivery model poses many challenges, not least that it requires providers to work in a way that is different to current practice, but also that currently, the Local, State and Commonwealth governments all play a role in policy and funding of the programs within the integrated service model in quite a fragmented manner.

Level 3 of the model will potentially drive the most substantial change from current practice and introduce new and innovative approaches for the sector to formally collaborate, not just at the coalface.

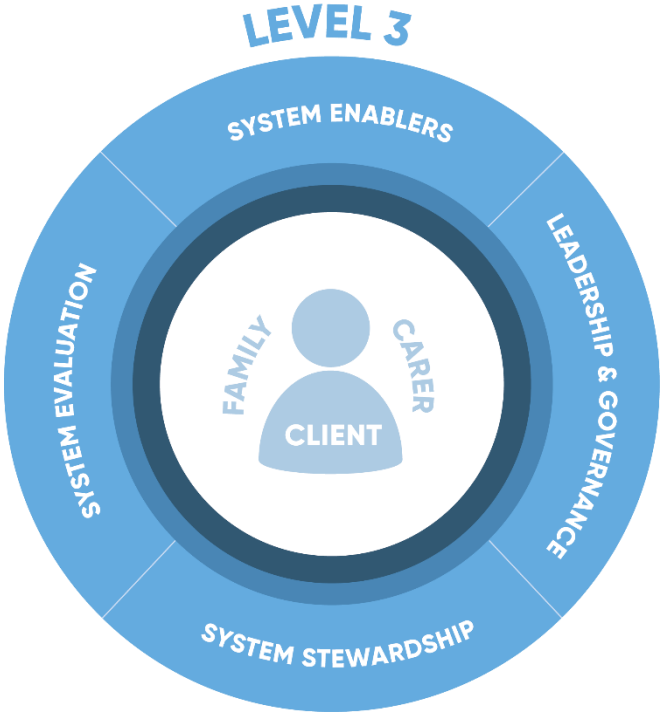
The model will require genuine collaboration between the three levels of government relating to significant structural support, including system oversight, co-design, and co-commissioning with flexible (blended) funding arrangements, among other things.

There is merit in investing time and resources into the establishment phase to ensure that Level 3 of the model is carefully planned and developed. The effectiveness of Level 3 will ultimately determine the ongoing ***sustainability*** of the entire integrated service model.

Level 3 services have been grouped into the four main elements, as shown in Figure 6-1 and described below:

- System stewardship;
- Leadership and governance;
- System enablers; and
- System evaluation.

Figure 6-1: Level 3 – System structure and support mechanisms



6.1. SYSTEM STEWARDSHIP

System stewardship relates to the over-arching governance structures that are designed to ensure system effectiveness, evaluation and performance management of providers. These are systems and structures determined by the system stewards (in this case the Commonwealth and State Governments) that clarify requirements and performance expectations of the service system. It may also include implications for non-compliance.

Stewardship implies responsibility for the effective operation and outcomes of the broader service system, whilst not necessarily having direct control over all of the facets that might make up a service system.

There are several recognised functions for the system steward that are particularly relevant for this model of integrated service delivery, including:

- *Setting service priorities* and ensuring that these and the expected outcomes are widely understood;
- *Allocation of funding and funding methods*, that is, setting the amount of funding to be directed to the service/policy and the basis on which the funding is to be allocated; and
- *Monitoring high level outcomes* and setting the measures that can enable assessments to be made as to whether policy goals have been achieved.

These functions and the requirements for effective implementation are described below.

6.1.1. Service priorities

A key success factor for the integrated service model will be governmental leadership that provides *clear and consistent messaging* in relation to policy direction, service priorities and expected client outcomes for the public investment.

Requirements for effective implementation – service priorities

- Endorse a formalised and collaborative approach to planning, funding and oversight of mental health and wrap-around services, where improved health outcomes are the focus.
- Set service priorities and ensure that these and the expected outcomes are widely understood.
- Provide clear and consistent messaging to the sector and the broader community in relation to service priorities and expected client outcomes for the public investment.
- Communicate the process for change.

6.1.2. Funding

The existing varieties of funding are recognised as contributing to the fragmentation of care, and the siloed practices of individual service providers. The current programmatic structure, with discrete funding and accountability mechanisms, promotes siloed service provision, ill-suited to respond to clients with multiple and complex needs in a local area where there is significant cross-over in Commonwealth and State funded services.

Although challenging, the development of a pooled funding approach is seen to be a critical component of the broader system reform. In a pooled funding approach, funding from multiple parties is combined to *commission* services, typically through a single contract. Parties may have direct oversight of their individual investment, but the outputs and outcomes are shared.

Transition to a pooled funding model will take time and should be tackled in stages. In the short to medium term, notional program funding allocations could exist within the broader 'pool' of flexible funding at a provider/client level, that could be reconciled to the program-based services delivered by providers. This means that in the short-term there could be clear program goals that are built into a transitioning accountability framework.

Pooled funding is only a first step. In the medium to longer-term there could be:

- Funding mechanisms that recognise client specific 'bundled payments'[6]; and ambitiously,
- Funding that is linked to client outcomes.

From the perspective of a funding approach, it will be important that the selection of client services can take place *at the coalface*, in collaboration with the client, to align with the integrated service delivery model. However, it will take a certain level of provider maturity to be able to achieve this.

Notwithstanding the above developments that more effectively support an integrated service model, it is recognised that *changes to a client specific bundled funding model will be a major driver of change toward effective integration in the sector.*

6. Bundled payments represent an alternate form of funding that is designed to move toward value-based care by incentivizing providers to advance coordination and efficiency of care while also improving quality and outcomes.

Requirements for effective implementation - funding

- A trial or pilot program of an integrated service model would be supported by commensurate (albeit progressive) changes to a funding model. This would come at the expense of fee-for-service payment models, and payment on inputs, or block grants to specific entities.
- Incentivise providers to operate collectively, develop common tools, use integrated client records and information systems that are accessible to other providers, clients, families and carers.
- Leverage funding to stimulate immediate and long-term improvements in performance in integrated care.
- Encourage ongoing investment by service entities in prevention and early intervention activities.
- Reinforce the benefits of integration through health system reinvestment of savings achieved through the integration of care into direct client care.

6.1.3. Accountability and performance management

A necessary adjunct to a new integrated service system will be an effective and complementary *performance management framework*. The framework will need to include:

- Agreed and clearly defined collective objectives;
- The process and nature of performance information to be collected to assess how the objectives are being met;
- Clearly specified targets and benchmarks for performance;
- Agreed standards to which services will be delivered (and entities held accountable); and
- The basis for providing transparent information on performance.

It is expected that there will need to be a mechanism within the DHHS (in particular) in its role as steward that reconciles the funding allocations, with pooled and individualised client funding at the coalface. This reconciliation or funding alignment task could be made relatively straightforward in the medium to long-term where client-level activity databases can differentiate program related services delivered to each client, which can then be programmatically aggregated.

Effective accountability will rely upon having reliable data on all of the main domains of the service model, activity levels and costs.

Requirements for effective implementation - accountability and performance management

- Agree the respective inputs and contributions from the engaged entities at the outset.
- Agree goals, measures, benchmarks and expected results that serve to reinforce an integrated service model.
- Develop a performance management framework, including both of the above points.
- Ensure consistent reporting as agreed across all engaged entities.
- Commission a formal evaluation of the service model.

6.2. LEADERSHIP & GOVERNANCE

Local system leadership and governance relates more to a system manager function. There is an expectation that there is local governance and leadership in driving the service model; including its design and implementation.

In the early phases of any new system, the leadership and governance arrangements need to be flexible to accommodate the different interests and involvement of the engaged entities, and to focus

on both strategic and operational priorities. Nevertheless, it operates within the parameters set by the system steward(s).

6.2.1. Strategic leadership group

It is proposed that an overarching **Strategic Leadership Group** be established that comprises representatives from State Government Departments, Local Government, Eastern Melbourne Primary Health Network and key decision makers from the identified lead agencies. The Strategic Leadership Group would have overall responsibility for:

- Strategic planning, including establishing the shared vision and aims of the integrated service model, assessing community need, service commissioning; and developing a program logic and identified outcomes for the shorter and longer term.
- Enacting formal multi-lateral provider agreements that incorporate, for example clinical governance and practice standards, funding approaches, and quality standards;
- Partnership development;
- Co-commissioning services;
- Facilitating system evaluation (through an independent evaluator);
- Resolving operational problems as they arise. The intention is that this group is responsive and can address issues in a timely manner;
- Monitoring system capacity;
- Developing shared resources and tools, including:
  - Common intake, assessment and referral protocols and templates;
  - Minimum data collection, data sharing and reporting requirements;
  - Workforce configurations, shared employment arrangements and exchange/secondment of workforce between providers;
  - Administrative arrangements;
- Developing and instituting required enablers, such as ICT and data sharing platforms and requirements and workforce training programs; and
- System adjustment and redesign.

Flexible organisational structures will be required to enable staff to participate in both the collective work (by being members of the strategic leadership or operations group), as well as the work of their own organisation.

6.2.2. 'Collective Impact' approach

Supporting a governance structure (and built into the operational protocols agreement) is an acceptable way of doing business between disparate service entities. One such approach is a Collective Impact Framework. "Collective impact" is suited to collaborative work to achieve social change.[7] Its premise is that large-scale social change requires broad cross-sector coordination but that the social sector remains focussed on isolated interventions of individual organisations. It has been noted that collective impact is frequently employed and demonstrated success in place-based settings.

The collective impact framework consists of five conditions drawn from case studies of collaborative projects that have achieved population-level change. The five conditions of collective impact are specified as:

7. Kania, J. & Kramer, M – Collective Impact, Stanford Social Innovation Review, 2011 - https://ssir.org/articles/entry/collective_impact#

- *A common agenda* – all stakeholders have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed actions.
- *Continuous communication* – consistent and open communication across the players to build trust, assure mutual objectives and create common motivation.
- *Backbone function* – Collaborative work requires a supportive infrastructure in the form of resources to coordinate participating organisations.
- *Mutually reinforcing activities* – participant activity must be differentiated while still being coordinated through a mutually reinforcing action plan.
- *Shared measurement system* – collecting data and measuring results consistently across all participants ensure that efforts remain aligned and participants hold each other accountable.

It is also helpful if all collaborating entities adopt a philosophy of "leave your ego at the door". This means collaborating entities need to be cognisant of:

- Not protecting individual organisational silos;
- Seeking and supporting ideas and decisions that serve the greater good, beyond that of the individual organisation;
- Recognising that creativity, wisdom and good ideas can come from any and many quarters;
- Not being afraid to try out new ideas and concepts; and
- Acting on and following through on those collaborative decisions taken by the collective.

6.2.3. Formal agreements

There are two types of formal agreements envisaged:

- An overarching *Strategic Agreement* amongst the governing bodies of participating entities; and
- An *Operational Protocol Agreement* that establishes the basis for the day-to-day guidelines, protocols and behaviours of each entity in the program.

An over-arching *Strategic Agreement* is an acknowledgement and commitment by all participating entities to the principles and objectives of the service model. It includes:

- A system stewardship framework and overarching governance group;
- A local governance group (with a local ad hoc problem-solving working group as required);
- Commitments to project principles; and
- Commitments to shared care, collaboration and accountability frameworks, amongst other things.

A *Strategic Agreement* would sit alongside, not replace, existing accountability mechanisms, bilateral contracts and organisational structures. It is envisaged that engaged entities might also vary existing contracts within the arrangement – for example, to align objectives and performance metrics, or commission additional services to support the new care model.

Operational Protocols Agreement. This Agreement establishes the basis for the day-to-day guidelines, protocols and behaviours of each entity in the program. The Operational Protocols Agreement sets the entry, triage, assessment, referral, planning and delivery guidelines, with a particular emphasis on common approaches, collaboration and integration. It would include:

- Processes and structures that enable client information referral and multi-entity development of care plans and services coordination;
- Client engagement/involvement in care planning and implementation; and
- The development of project accountabilities as they relate to access, screening, planning, care coordination, and seamless service/care delivery.

Design of supporting tools. These tools would be identified as a core part of the Operational Protocols Agreement and used by all entities in the project. They may be stand-alone tools, or 'bolted-on' tools to existing databases used by the various entities, including:

- Initial assessment and triage tool;
- Design of (central) client/family contact register, client care plan and care coordination register;
- Client risk tools, including self-management capability;
- Care Plan and care coordination repositories;
- 'Trusted person' and service navigator registers;
- KPIs, evaluation and client outcomes data sets and reporting; and
- Service cost data sets and reporting.

Requirements for effective implementation – formal agreements

- The development and signing of an overarching Strategic Agreement between participating entities.
- The development and signing of an Operations Protocol Agreement between all entities.
- The development of a range of operational common 'tools' that support integration.

6.2.4. Co-commissioning

Commissioning is a strategic, evidence-based approach to planning, purchasing, monitoring and evaluating services, which is outcomes-focused and centred on the needs of clients.

There will be greater potential for a collective impact on client outcomes if joint approaches to commissioning and service procurement are considered, where appropriate. Innovative cross-sector co-commissioning of services will rely on pooled funding, greater use of evidence-based measures to assess community need (jointly informed by client and provider input), clear accountability between government and third-party providers (the engaged entities) and clear monitoring and evaluation processes.

Most importantly, it will rely upon an unprecedented level of cooperation.

Requirements for effective implementation – co-commissioning

- Establish the necessary structures, information and tools required to support cross-sector commissioning / purchasing.
- Require a consistent basis for commissioning services across government departments.
- Enable transparency of commissioning / purchasing.
- Monitor and evaluate funded services to inform improvement in quality and outcomes of funded services.
- Engage providers and seek their buy-in to the new structures that emerge for commissioning / purchasing.

6.2.5. Partnership development

Partnerships are fundamental to the integrated service model. Effective working partnerships and relationships across the health and social care systems promote clear roles, accountability, trust, shared decision making and information sharing between partners.

Requirements for effective implementation - partnership development

- Form working partnerships across health services, other health services, non-government organisations and other government agencies.
- Formalise partnerships with executive level support to drive integrated care at the local level.
- Base partnerships on clear goals, with a shared understanding of and commitment to these goals.
- Ensure each partner understands the lines of communication, roles, responsibilities and expectations of partners, and is involved in setting priorities for collaborative action.
- Recognise and support staff who have roles that cross the traditional boundaries that exist between entities in the partnership.
- Develop a shared decision-making system that is accountable, responsive and inclusive.
- Standardise common processes across entities wherever practical.
- Provide regular opportunities for contact between staff across service partners to share information and best practice.
- Ensure partners can demonstrate the outcomes of their collective work and establish processes for celebrating collective achievements.
- Continually review partnerships and change as required.

6.2.6. Adjustment and redesign

The capability to deliver integrated health and social care requires an inbuilt process of adjustment and redesign in the service model.

There are two elements to this; adjustment as a short-term response to an individual problem, and longer-term system redesign. A model that has the capability to respond to what it learns and reconfigure accordingly will continually improve and ultimately better support both providers and their clients.

Short-term responses are usually undertaken by individual workers responding to issues as they arise in real time. Individuals often solve problems by creating their own unique workarounds. Although these responses are often locally effective and solve the immediate problem, they often do nothing to prevent re-occurrence and can inhibit longer-term redesign and improvement.

The leadership and governance group must assume that anomalies are going to occur in the integrated service delivery model. Consequently, a rapid response, in terms of both a resource with dedicated time and a mechanism for activating the response, needs to be built into the model as pre-prepared capability.

Requirements for effective implementation – adjustment and redesign

- Create specific team/s intended as a problem-solving resource;
- Determine whether the team composition is the same for all types of anomalies, or whether sub-speciality teams are required;
- Name the problem-solving team/s to suit the local circumstances. For example: Rapid Response Team, Rapid Process Improvement Team, Tiger Team, etc.
- Communicate the existence, purpose and process to activate the problem-solving team widely throughout the service delivery model to all engaged entities; and
- Agree on a formal process for the problem-solving team to follow upon activation, for example: define the existing process; establish measures and targets; observe, measure and critique the existing process; develop and trial an improved process; and implement.

6.3. SYSTEM ENABLERS

There are certain requirements to enable an integrated service model for youth with mental health needs in the Yarra Ranges to be successful. In addition to effective stewardship, leadership and governance of the model (as discussed above in Sections 6.1), there are other critical enablers the integrated service model will depend on, including data collection/reporting, information sharing, technology development, workforce development, and clinical governance.

6.3.1. Data collection, reporting and information sharing

Data collection and reporting is one of the most critical elements of the integrated service delivery model. It will be important that there is an emphasis by the key stakeholders to plan for the collection of the necessary data, and specific fields, at client level that can effectively:

- Identify the services provided;
- Identify key client participation measures; and over time; and
- Identify client outcomes, including self-measures.

Data reporting will need to be verifiable, complete, and consistent between providers.

This is a planned process that will be progressively refined over several years.

Requirements for effective implementation - data collection and reporting

- Establish a consistent and uniform data fields.
- Establish a data collection system; likely to be an adjunct to current systems.
- Ensure data is entered and reported in a timely and accurate manner.

6.3.2. Information sharing

The sharing of client information is pivotal to the seamless provision of care. Information flow and data sharing are essential building blocks of successful integrated care models. Digital records can play an important role in facilitating seamless delivery of person-centred coordinated care, through supporting:

- Care planning tailored around the needs, strengths and goals specific to each individual, including the co-production of care plans with individuals;

- Care coordination by multidisciplinary teams and professionals across care settings, ensuring all decisions about an individual's treatment and care pathway are based on shared and up-to-date health and care information; and
- Continuity of care for people moving through the health and care system, by making relevant information accessible to all professionals and services involved.

In addition, joined-up working between health and social support services facilitated by sharing information eliminates duplication, including multiple assessments (retelling the client story) which in turn results in a better care experience for the client.

Requirements for effective implementation - shared information

- Develop secure information flow portals.
- Secure client support for information flow between entities.
- Enable client-level access to their own care plan;
- Establish robust information sharing processes to support rapid communication between providers.
- Utilise data linkage and analysis to support care planning and decision-making.
- Support service development and quality improvement with data linkage and analytics.

6.3.3. Information and Communication Technology (ICT)

If information flow is pivotal to the proposed model, then the technology to enable the information flow is equally important.

Core components of Level 1 of this model, namely screening, comprehensive assessment and multi-provider care planning and coordination, rely on the establishment of a (central) data repository of information or registers that all engaged entities commit to using to share client level information. The (centralised) database may be accessed (either for modification or for viewing only) by providers and clients and their family/carers via a web portal.

A database could work in two ways, for example:

- All engaged entities adopt standardised screening, assessment and care plan tools. Entities could enter the collected information into their existing client management systems, and push client information across to a database; or
- All engaged entities keep their current tools and push client information across to a database which can collect all client tools used across the engaged entities. This requires identification of all screening, assessment and care plan tools used by the entities and the generation of automated logic rules to determine fields to be pushed to the centralised database.

A database for screening, assessment and care planning and coordination may be enhanced with the generation of or identification of an existing valid Statistical Linkage Key (SLK), such as the SLK-581 (client identifier), to allow data linkage to occur with other minimum datasets.

Currently, there are a number of national minimum datasets (NMDS) that can be linked via a SLK-581 that may pertain to the client cohort, including but not limited to:

- Admitted mental health-related care (same day and overnight admissions for public and private);
- Community mental health care;
- Residential mental health care;
- Disability services;
- Homelessness;

- Alcohol and Other Drugs;
- Medical Benefits Schedule; and
- Pharmaceutical Benefits Schedule.

Requirements for effective implementation – ICT

The most suitable options for capturing, storing and sharing information electronically (the database) depend upon a number of factors, including resource intensity, establishment time, cost and legislative and regulatory requirements. The pursued options would need to be determined and agreed upon by all engaged entities, the DHHS and the EMPHN.

Notwithstanding this, future ICT development should broadly focus on four main areas:

Enhancing connectivity between engaged entities;

- Explore opportunities for common technology and system platforms and shared investment across health and social care;
- Develop incentives for entities to invest and engage in meaningful technology to support connectivity; and
- Enable the timely referral and 'booking' for client appointments between engaged entities, including GPs.

Transfer of clinical information:

- Develop systems which will support access to real-time information as required;
- Increase investment in telehealth and other telecommunications infrastructure (and associated clinical protocols and guidelines) to support integrated care;
- Ensure platforms are secure, and information practices address the privacy and confidentiality concerns of clients and providers; and
- Ensure clients, and potentially their families or carers, have access to their electronic shared care plan to support them as partners in their own health care.

Remote location client monitoring:

- Increase the use of technologies that allow more seamless and accessible care to be delivered. This may involve remote monitoring, delivered by a single provider or multidisciplinary team, or case conferencing between providers;

Management support systems:

- Capture activity data, resources and client outcomes, in order to have the necessary 'evidence-base' to demonstrate effectiveness; and
- Use social and new media effectively as part of a generational change in the approach to communication with the cohort.

6.3.4. Workforce

Sustainable change is not possible without cultural change within the workforce. Providers within the system must shift their thinking to a service culture that operates as one integrated system, inclusive of multi-disciplinary, multi-provider care that focuses on the holistic needs of the client. Cultural change requires the system providers to have the capacity to appropriately adapt and will depend somewhat on the organisational maturity, stability, capability and resilience.

Requirements for effective implementation

- Each engaged entity promotes understanding of the shared vision, aims and value of the integrated service model within their workforce.
- Change management methodology is used to transform workflow practices towards integrated care.
- Shared employment arrangements and exchange/secondment of workforce between providers is facilitated.
- Providers are given regular opportunities to build relationships and trust with their peers.
- Influential leaders promote the integrated service model through forums and other communication.
- There is a shift from a discharge of care approach to a transfer of shared care approach.

6.4. SYSTEM EVALUATION

A service model that is designed to provide integrated care for mental health, physical health and social needs will be continually evolving and improving. The principles, enablers and expected outcomes may change as the implementation progresses and therefore, system evaluation measures should be reviewed over time.

Notwithstanding this, there are some high-level questions that should inform the system evaluation framework, incorporating the domains of appropriateness, efficiency and effectiveness:

Appropriateness	To what extent does the integrated service model address the needs of the client cohort? Are the principles of the integrated service model guiding activity? How well does the integrated service model align with government and entity priorities?
Efficiency	Do the outcomes of the integrated service model represent value for money? To what extent is the relationship between inputs (resources, costs) and outputs timely, cost-effective and to expected standards?
Effectiveness	Is the model achieving its intended purpose? To what extent are improvements in client outcomes attributable to the integrated service model? Are the enablers supporting the integration of care? Is the model achieving its intended purpose?

Development of a program logic to evaluate Levels 2 and 3 of the model will allow for specific activities within each element to be mapped to more granular evaluation measures. Shorter- and longer-term outcome measures should also be developed. Measures should be feasible, valid and reliable and align with the stage of implementation. Suggested areas include:

6.4.1. Level 2 evaluation

Model element	Areas for evaluation
Universal information	Service directory use (views / contacts)
	Client experience of the service directory platform
	Provider experience of the service directory platform
Proactive prevention and early intervention	Community settings identified
	Program delivery into community settings
	Resource toolkits

Model element	Areas for evaluation
	ED presentations and unplanned acute readmissions
Capacity building	Communication plan
	Integrated care forums
	Cross sector information sharing and training programs
	Workforce capability

6.4.2. Level 3 evaluation

Model element	Areas for evaluation
Leadership and Governance	Shared vision and aims
	Shared accountability and responsibility for system processes
	Shared accountability and responsibility for client outcomes
Partnerships	Multi-lateral provider agreements
	Multi-provider and multi-disciplinary work teams (across health and social services)
	Clear roles and responsibilities
	Shared decision making
	Standardised common processes
Funding	Collective incentives of funding
	Flexibility of funding
	Economic benefits
Technology	Real-time access to information
	Telehealth / telecommunication use
	Communication between providers
	Communication with clients and their families and carers
Shared Information	Linked client data
	Central databases
	Minimum shared data
	Standardised common tools
	Client access to their own care plans
	Integrity, privacy, confidentiality
Workforce	Collaborative workforce agreements
	Multi-provider and multi-disciplinary education and training
	Opportunities for relationship building and information sharing
	Workforce adequacy (role, skill, number, distribution, etc)

6.4.3. Outcome evaluation

Element	Areas for evaluation (in the shorter and longer term)
Client centred care	Client's self-management abilities (understanding of and promotion of) Carer support Client involvement in shared decision making Client involvement in shared care planning Client access to their own care plans Client feedback on the quality and continuity of care received
Care coordination	Joint planning between health care and social support providers Named care coordinators Seamless / warm referrals Inclusion criteria for multi-provider care planning and coordination Defined care pathways
Client reported outcome measures*	Generic PROMS such as physical functioning, psychological symptoms, social functioning, pain, etc. Condition specific PROMS, such as self-reported psychological distress, etc. Patient reported outcomes - performance measurement (PRO-PM); assessment of performance using PRO data aggregated across organisations.

**There are a number of validated tools available for capturing client related outcomes including Patient Reported Outcomes (PROMS), PRO-PMs and Client Satisfaction Questionnaire (CSQ-18) amongst others.*

Level 3 of the integrated service delivery model addresses current issues with service integration, funding arrangements, workforce, data collection and outcome measurement and governance and accountability.

7. Implementation

Implementing change is complex and dynamic and often requires transforming from something familiar to something new – *a different way of doing business*. Changes can affect the different entities, or parts of entities, at a broad level, (i.e. affecting multiple people and/or practices or aspects of the program) or it might be more limited. Regardless of the scale, change is an active and on-going process, rather than a single event - *it will take time, will require flexibility and tolerance and must be underpinned by some fundamental building-blocks*.

Detailed below is an outline and rationale for features considered to be essential for the success of implementing the integrated service model. Table 7-1 provides a summary of early (pre-implementation) tasks as well as tasks that can be developed/refined over the years.

7.1. GOVERNANCE

Establishing the appropriate governance structure is fundamental to the successful development of an integrated service model. The right governance arrangements ensure the survival of the collaborative arrangements and the processes that influences decisions and actions of the collaboration that are required for delivering the integrated service model .

The key structure needs to be in place prior to the implementation of the service model.

The governance arrangement proposed for providing the leadership decision making is at two levels.

- ***Strategic Leadership Group*** will be responsible for setting the overarching direction for implementing the model. It provides the system stewardship role.
- ***Operations Group*** would consist of more operational personnel from each participating entity who would be responsible for ensuring the local leadership and project governance. This group needs to be flexible and responsive in order to problem-solve as issues arise.

The objective is to develop “collaborative governance” involving cooperative leadership for cross-sector collaboration amongst participating entities that share a common goal or outcome. Although the sectors may refer to the public, private for-profit and non-profit arenas, or to different public policy domains; the concepts, challenges and opportunities for cross-boundary collaborative systems remain shared or similar.

7.2. AGREEMENTS

At the higher level, there will need to be an overarching Strategic Agreement that contemplates the key aspects of the collaborative engagement across engaged entities, including arrangements for shared governance, a shared vision, commitments to make better use of resources together, agreements to integrate the delivery of services and accountability frameworks.

At the operational level and operating within the parameters of the Strategic Agreement, an Operational Protocols Agreement is proposed. See Section 6.2.3.

Both types of agreement would need to be in place prior to the commencement of the service model.

7.3. TOOLS

Timely and consistent communication among service providers is important to inform decision making. As such, shared processes, guidelines and tools for working together will support service providers in a model of integrated care. This should include:

- Co-developed shared needs assessment screening tool;
- Co-developed shared referral tool;
- A shared care plan, complemented by consistent use of technology (see below);
- Co-developed minimum requirements for information outlined in shared communication guidelines; and
- A single directory for care providers and consumers.
- Initial assessment and triage tool;
- Design of (central) client/family contact register, client care plan and care coordination register;
- Client risk tools, including self-management capability;
- Care Plan and care coordination repositories;
- 'Trusted person' and service navigator registers;
- Common activity data, and client outcome/experience data collection protocols;
- Common cost collection protocols; and
- Co-developed performance measures and reporting.

7.4. OPERATIONAL PROTOCOL

Effective integration is reliant on ensuring clear roles, responsibilities and protocols for engagement across the various engaged entities. It is recommended that the Operations Group develop an agreed operations protocol, agreed and endorsed by the Strategic Leadership Group, that is shared amongst all engaged entities. The protocol should include the fundamentals of how engaged entities work together to achieve a common goal for the client. The protocol should include amongst other things:

- Key contact information for each engaged entity;
- Key services provided;
- Hours of operation and key contacts for after-hours;
- Organisational chart;
- Eligibility criteria;
- Process and structures that enable joint development of care planning;
- Process for ongoing sharing information;
- Processes for advising/sharing individual entity changes with other engaged entities;
- Procedures for inter-entity staff engagement/meetings;
- Dispute resolution with respect to case practice differences;
- Development of project accountabilities as they relate to access, screening, planning, care coordination;
- Agreed process for maintaining client level data across engaged agencies; and
- Agreed timeframe and nominated person/engaged entity for maintaining protocols.

7.5. DEMONSTRATING VALUE

An important characteristic of model implementation is to establish what success looks like across all of the key dimensions of the service model.

This requires co-design of the expected performance measures, and possibly benchmark performance for the model. This sets early expectations for the model, and greater understanding of the expectations from each entity.

It is expected that some core performance measures will be established prior to the implementation of the service model. Others will be added and refined as implementation is underway.

7.6. ICT (SHARED DATA)

A major barrier to sharing care and creating a seamless service pathway in providing integrated care is incomplete or untimely access to information. In an ideal world there would be seamless interface between engaged entities ICT systems to enable real-time access to relevant client information. Despite the likely disparate nature of existent systems, there are potential steps to improve short-, medium- and long-term progress towards shared-information systems, including:

- Encouraging system, software and behaviour uptake;
- Defining minimum data and information required by different parties to be effective in their role; and
- Enabling two-way electronic communication between care providers.

As previously discussed in sections 6.3.2 and 6.3.3, it is imperative for the success of this model that screening, comprehensive assessment and multi-provider care planning and coordination, rely on the establishment of a central repository of information (centralised database) that all engaged entities commit to using to share client level information.

Table 7-1: Summary of Key Tasks

BEFORE COMMENCEMENT	PROGRESSIVE DEVELOPMENT	LONGER TERM
Shared vision and governance ▪ **Establish** a high-level governance structure (Strategic Leadership Group) ▪ **Jointly develop** the shared vision for the integrated model for youth mental health. **Commitment** ▪ **Obtain** funding support from government to implement and ongoing commitment to an integrated model of service delivery. **Joint assessment & planning** ▪ **Assess & confirm** current services to understand extent of services and where there are exemplars of good practice. ▪ **Design** the ideal integrated service model to meet the needs of the youth mental health cohort. ▪ **Define** the roles/responsibilities of the individual engaged entities for ideal operation of an integrated service model. ▪ **Agree** a plan for achieving the identified common outcomes. **Shared processes, guidelines and tools** ▪ **Co-develop and agree** guidelines for transfer of information that encourages engaged entities to develop cross-sector working relationships. ▪ **Identify** enablers, tools and resources to achieve integrated care.	**Mature** ▪ **Continue to develop** leadership and funding commitment to drive shared integration agenda. **Information sharing** ▪ Establish the ICT to facilitate information exchange **Information platform** ▪ **Adopt** a common platform and systems for information sharing and care planning. **Incentivise service providers** ▪ **Progressively develop and refine bundled payment** funding arrangements by examining what resources are needed to deliver the most integrated services. ▪ **Develop** KPIs that reflect and align to the agreed shared vision and incorporate into each engaged entity's performance frameworks. ▪ **Identify** measures that can be incentivised for service providers. **Shifting existing behaviours** ▪ **Develop and deliver** interdisciplinary training to build capacity amongst providers to work collaboratively. ▪ **Encourage** use of individualised shared care plans across providers. **Client, family/carers engagement** ▪ **Engage** the client and family/carers in care planning activities. ▪ **Educate** clients and family/carers about available services. **Workforce development** ▪ **Develop and grow** the necessary workforce to ensure requisite expertise for delivering integrated services across the spectrum of care.	**Evaluate** ▪ **Undertake** ongoing evaluation and monitoring of integrated processes to inform continuous performance improvement. ▪ **Encourage** continual refinement and adaptation of models and services to meet changing population health needs.

A1. Stakeholders consulted

The following people were consulted either face-to-face or by teleconference.

REPRESENTATIVE	ORGANISATION
Peter Dinsdale	Anchor
Helen Philip	Anchor
Celeste Haddock	Anglicare
Gus Seremetis	Cire Services
Richard Lough	EACH
Warren Turner	EACH
Lynne Allison	Eastern Health
Cathryn Baldwin	Eastern Health
Jo Petrenko	Eastern Health
Peter Brann	Eastern Health
Kate Gibson	Eastern Community Legal Centre (ECLC)
Youna Kim	Eastern Domestic Violence Service Inc (EDVOS)
Aaron Jones	Eastern Melbourne Primary Health Network
Stacey Thomas	Eastern Melbourne Primary Health Network
Sharon Patton	headspace
Maria Romanin	Healesville Indigenous Community Services Association
Gillian Smith	Inspiro: Community Health Service
Andrea Waugh	Inspiro: Community Health Service
Jenny Royle	Outer Eastern Local Learning & Employment Network (OELLEN)
Fiona Purcell	Outer Eastern Local Learning & Employment Network
Lisa Brooks	Vic Police
Linda Hancock	Vic Police
Jason Goddard	Vic Police
Loren Hedger	Yarra Ranges Council
Mona Ray Greig	Yarra Ranges Council
Anita Holman	Yarra Ranges Council
Guy Masters	Yarra Ranges Council
Corinne Bowen	Yarra Ranges Council

Input was also sought from the following people/organisations via email.

REPRESENTATIVE	ORGANISATION
Heidi Tucker	Anchor
Melina Anastassiou-Stein	Anchor
Helen Philip	Anchor
Meg Beilken	Department of Education and Training
Susan Thompson	EACH
Michelle Flemming	Eastern Health
Nicole Harris	Eastern Health
Tina Kelson	Eastern Health
Fiona Sedgman	Eastern Health
Chris Walsh	Eastern Community Legal Centre (ECLC)
Brianna Myors	Eastern Domestic Violence Service Inc (EDVOS)
Joel Robins	Eastern Melbourne Primary Health Network
Rodney Donald	Healesville Indigenous Community Services Association
Lara Clark	Inspiro: Community Health Service
Sue Sestan	Inspiro: Community Health Service
Mark Dixon	Uniting
Stephen Milliken	Uniting
Jake Brown	Yarra Ranges Council
Jess Whatttam	Yarra Ranges Council
Steve Cornell	YSAS