Mental Health Strategic Plan

2019 – 2021

St Vincent's Darlinghurst Campus, Sydney

ST VINCENT'S HOSPITAL SYDNEY

ST VINCENT'S PRIVATE HOSPITAL SYDNEY

Funded by: ST VINCENT'S CURRAN FOUNDATION

Introduction

The site of our first Mental Health Unit, 'Reception House' as it was known, sat adjacent to the then Darlinghurst Gaol and served to observe and provide psychiatric care to inmates, back in 1868. When the Sisters of Charity opened our doors in Darlinghurst in 1870, it is said that the first patient at was a mental health patient, based on their mission to provide care to the vulnerable.

Our leadership in the mental health space has continued since then but is no longer confined to Darlinghurst. Rather, with innovative digital and online care delivery, we are now reaching people with mental health concerns across NSW, in remote and rural areas and indeed even abroad with award winning services such as This Way Up, and SOS Telehealth.

On the ground, our speciality services including early intervention programs, inpatient services and our outreach community services ensure that we are meeting the needs of our local community, characterised by some of the country's highest levels of urban social disadvantage including homelessness, chronic mental illness, substance use and other complex health needs.

Hand-in-hand with our clinical work, we have long committed to mental health research with dedicated research units Faces in the Street (urban mental health) and CRUfAD (Clinical Research Unit for Anxiety and Depression) as well as our Research Unit for Schizophrenia Epidemiology, ensuring that our evidence based delivery of mental health services continue to raise the bar in effective, results-driven treatments.

As you will see in this plan, our multi-strategy vision to take our current successes and propel St Vincent's further into an even more effective and specialised provider of mental health services forms an integral part of our key strategic activities and remains an absolute priority for our Campus.

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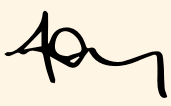

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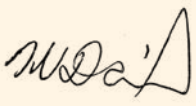

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ST VINCENT'S HOSPITAL SYDNEY

ST VINCENT'S PRIVATE HOSPITAL SYDNEY

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Personal: The Future of Darlinghurst Mental Health Services

Our Vision

Our mental health services are rooted in our Mission. We are:

P Providing person-centred and person-led services that meet the **needs of our population**

E Ensuring **coordination and integration** with other health and care services

R Responding to the needs of **families / caregivers** and providing clear information on what to expect

S Striving to deliver services that seek to **prevent** the onset or advancement of **mental ill health**

O Organising services to be **cost-effective** and deliver **value** for the payer, whether they are public or private

N Navigating **other health services** to appropriate mental health support, ensuring they consider the mental health needs of their consumers

A Accomplishing the **highest standards of clinical practice**, through motivated and engaged teams

L Leveraging our research capabilities and **translating world-leading research** into our clinical practice.

Enablers

Family & Carer Support

We will be leaders in family & carer support across Australia. Our Centre for Family Based Therapies is already providing education in Family & Carer therapy to providers beyond the borders of New South Wales. We will build on this reputation and galvanise our clinicians across the campus to offer an experience to families and carers that is truly different, and aligned to our core mission and values. All consumers, families & carers will feel welcomed, safe and valued.

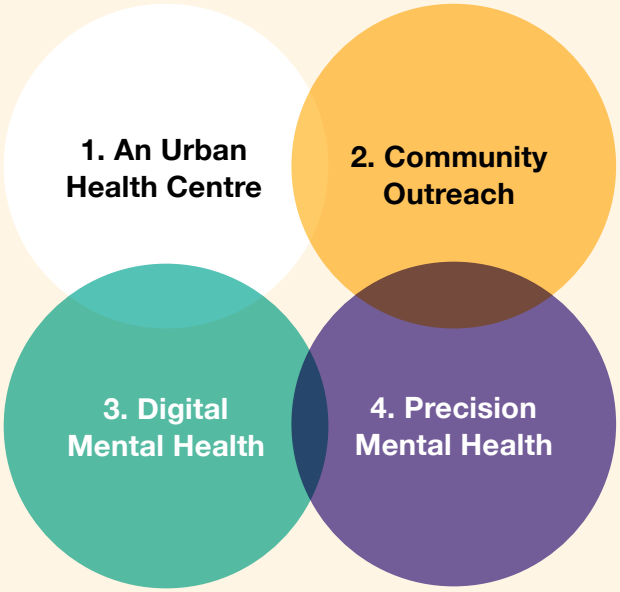
Teaching, Research & Education

We will generate more than $1m in new research and innovation funding each year to support testing and translation of new care innovations into our practice, aligned to our priorities.

We will educate a workforce of the future, through:

- A reputation as a leader in clinical supervision and training, using our partnerships with UNSW, University of Sydney, Notre Dame and ACU to attract new talent and create professional education pathways
- New workforce models, drawing on our peer workforce and creating nurse practitioner roles to support and enhance our services

Our Priorities



1 **An Urban Health Centre**
We will work with our community and our community partners to co-design an Urban Health Centre to deliver an early intervention and holistic approach to meeting the unique and different health and care needs of our urban population.

The Urban Health Centre will be a central extended 'hours' hub to support consumers and their families, and provide connectivity and access to other services.

2 **Community Outreach**
We will grow services beyond the hospital walls, to extend our Mission and support our priority groups, including provision of high quality care and research excellence, through:

- Progressing rapidly the development of a Prevention and Recovery Centre, to provide step-up and step-down care.
- An expanded community team, Older Person's Mental Health Service and USpace Youth Mental Health Program

3 **Precision Mental Health**
Precision diagnosis and targeted treatment and care for patients to deliver the best possible outcomes for them. We will increase our understanding of neurobiology and pharmacogenomics to provide tailored treatments, which are goal and evidence based.

Tailored treatments will range from personalised exercise and wellness programs through to tailored drug treatment and procedure based programs

4 **Digital Mental Health**
We will continue to be Australia-leading in the innovation of new eHealth programs for Anxiety & Depression through CRUfAD, and expand this to other patient groups.

Virtual care delivery will be embedded within our service delivery model, and we will look beyond current approaches to incorporate AI, deep learning and virtual reality augmented therapies as the evidence base and use cases mature.

Our Philanthropy

We will continue to use philanthropy to accelerate service innovation and change to benefit our community

1 Background

1.1 The impacts of mental ill-health

Each year almost 1 in 5 Australians experience mental ill health, with 45 per cent (7.3 million) of Australians aged 16 to 85 experiencing a common mental health disorder, such as depression, anxiety or substance abuse disorders in their lifetime.[1] Based on national prevalence rates, estimates suggest that 20,000 persons in the local catchment area identify themselves as suffering from a mental health disorder within the last 12 months.

Mental health is more prevalent in disadvantaged groups and a sizeable proportion of the Darlinghurst local population is characterised by significant socio-economic disadvantage, including high levels of public housing, low income households, and a sizeable population that suffer from homelessness and/or substance abuse. People living with mental illness, are at greater risk of experiencing a range of adverse health outcomes and have a lower life expectancy than the general population.

Our mental health services are a core part of the organisation's commitment to providing care to disadvantaged and marginalised members of our community, and providing high quality mental health services is a mission imperative for us.

1.2 Strategic Context

1.2.1 enVision 2025

Serving something greater

St Vincent Health Australia's vision for the future, enVision 2025 reaffirms the commitment of St Vincent's to preferentially care for the poor and vulnerable, identifying five priority groups:

- Those who are homeless
- Those with mental health conditions
- Those with drug and alcohol addiction
- Aboriginal and Torres Strait Islander People
- Those in the justice system.

Seeing something greater

From humble beginnings, St Vincent's Health Australia has become the largest Catholic not-for-profit health and aged care provider in the country. enVision 2025 invites the organisation to think big so we can see a much more profound impact on the lives of millions of Australians.

Striving for something greater

St Vincent's Health Australia has a reputation for innovation and clinical excellence. enVision 2025 impels the organisation to constantly strive for something greater, to continue to develop cutting-edge research and translate this into better clinical practice.

1.2.2 The Darlinghurst Campus Strategy

In 2017, the Clinical Services Strategy for Darlinghurst was published. This sets out a clear vision for an Integrated Healthcare Campus at Darlinghurst, based firmly on enVision 2025. It includes six strategic commitments for the campus:

1. Our future is precision medicine. We will provide innovative and personalised care through minimally invasive, targeted interventions, leveraging genomics, advanced imaging, microbiome and metabolic analysis.

2. We will introduce new ambulatory models of integrated care. Patients will have access to coordinated, specialist interdisciplinary teams that treat the whole person and are fully integrated with primary care.

3. We will use telehealth and virtual care delivery to provide outreach services to patients and support to clinicians in remote and rural areas, ensuring all NSW patients can access specialist care.

4. We will be a destination for world class treatment, research and training, with a Centre of Excellence in Heart Lung Vascular, and a number of other preeminent clinical services.

5. We will continue to advocate for and deliver compassionate care and service the poor and vulnerable in the spirit of Mary Aikenhead and the Sisters of Charity.

6. We will develop more cost effective models of care for patients using precision medicine, integrated care and telehealth, and leverage the capabilities of our co-located public and private healthcare campus.

The Mental Health Strategic Plan has built on, and exemplifies these commitments.

1.2.3 The NSW Strategic Framework and Workforce Plan

During the development of this Strategic Plan NSW Health published their Strategic Framework and Workforce Plan, which sets out key priorities for the State, including three goals for focussed action over the next five years:

- **Goal 1** – Holistic, person-centred care
- **Goal 2** – Safe, high quality care
- **Goal 3** – Connected Care

Our Strategic Plan is strongly aligned to these goals, and to the priority areas for action that sit beneath them.

1.3 Our Current Service

St Vincent's Hospital Sydney serves as a leading provider of healthcare services to communities across Sydney and Australia and has an earned reputation of providing effective, safe, and high quality care that places emphasis on being person centred and involving families. St Vincent's Private Hospital Sydney, located adjacent to the public hospital is also focused on excellence and innovation in care delivery. The construction of a new 13-storey East Wing was also completed during the year. The major redevelopment includes 50 additional beds, a new ambulatory care service, two new theatres, a new rehabilitation service, and additional doctors' consulting suites

Our mental health services perform reasonably well against State benchmarks, with notable excellence in patient satisfaction (See Appendix 1). Other particular strengths include:

- An innovative model of care for Older People's Mental Health, through interdisciplinary team-based care and extensive outreach into the community, including through the Psychogeriatric SOS program which provides support to remote and rural clinicians via telehealth

- CRUfAD's This Way Up program, which operates as a Commonwealth funded national service providing treatment for anxiety and depression

There are, however, a number of significant challenges facing our mental health services, which need to be addressed:

- High volumes of out of area patients putting pressure on beds and mental health resources

- A shortfall in mental health staffing at the campus across all disciplines

- Inadequate timely follow-up and community support

There are also a number of existing initiatives underway within the service. This includes our planning to address the issues raised in the 2017 NSW Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness, which includes regular monitoring and review of all instances of seclusion and restraint, and a number of facility upgrades. We have also developed a plan for additional sub-acute mental healthcapacity on the Cahill Cater site to address anticipated increases in demand This Strategic Plan is in addition, and complementary, to these existing initiatives.

2 Vision

To provide accessible, responsive and personalised services to meet the mental and physical health needs of our population when they or their loved ones experience, or are at risk of experiencing a mental health problem.

In consultation with clinicians, consumers and mental health staff a vision for mental health services was articulated. The vision drives a focus on the 'personal', with patients, their families and caregiver network centre to the integrated model of care. This means:

Providing person-centred and person-led services that meet the **needs of our population**

Ensuring **coordination and integration** with other health and care services

Responding to the needs of **families /caregivers** and providing clear information on what to expect

Striving to deliver services that seek to **prevent** the onset or advancement of **mental ill health**

Organising services to be **cost-effective** and deliver **value** for the payer, whether they are public or private

Navigating **other health services** to appropriate mental health support, ensuring they consider the mental health needs of their consumers

Accomplishing the **highest standards of clinical practice**, through motivated and engaged teams

Leveraging our research capabilities and **translating world-leading research** into our clinical practice.

3 Delivering Against Our Vision

3.1 Comprehensive Mental Health Services

We will deliver new services and care innovations that meet the needs of our priority populations and are commercially viable, and strengthen our core services to deliver the highest quality care.

Figure 2

Current and Future Services

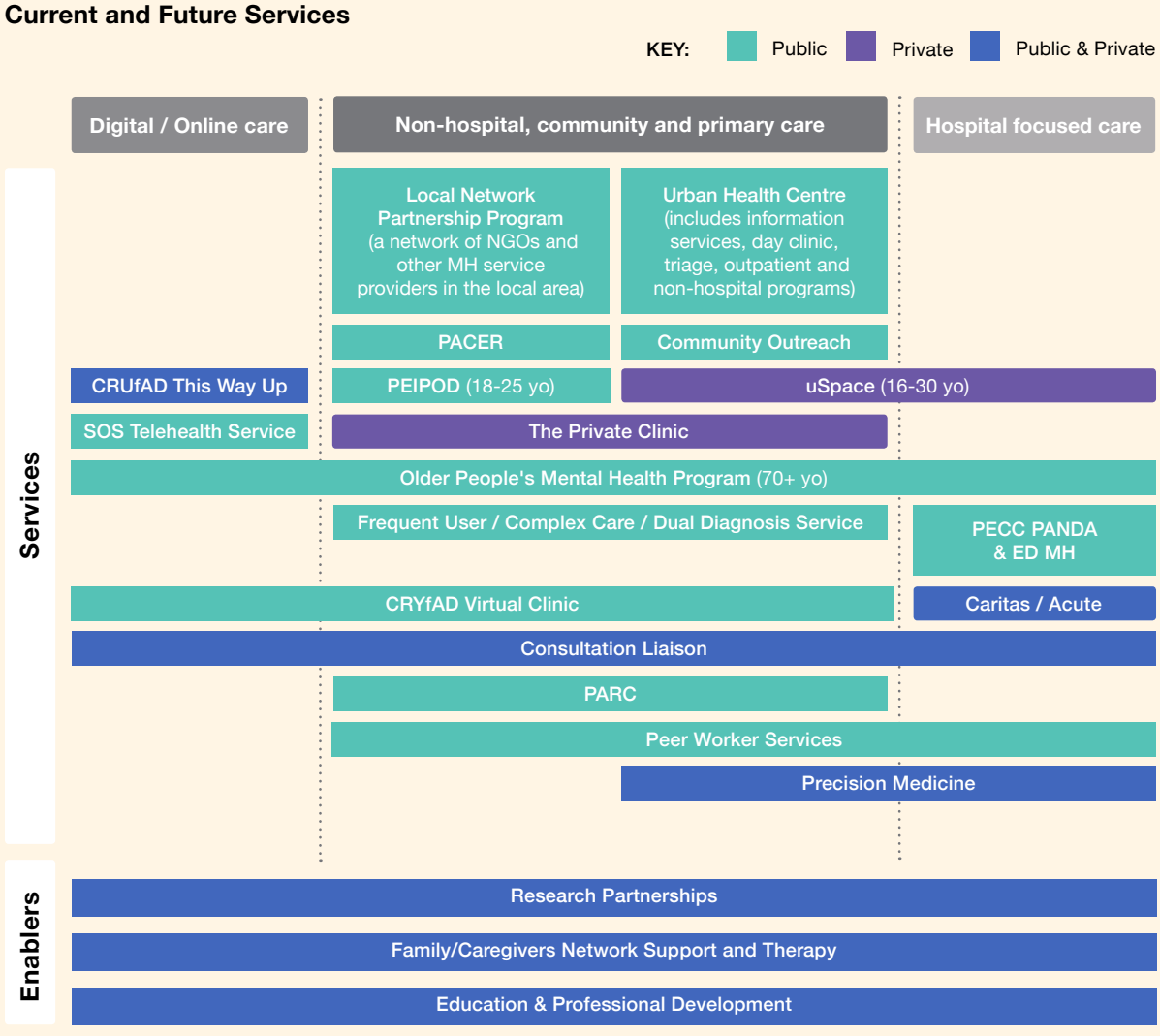


Figure 3

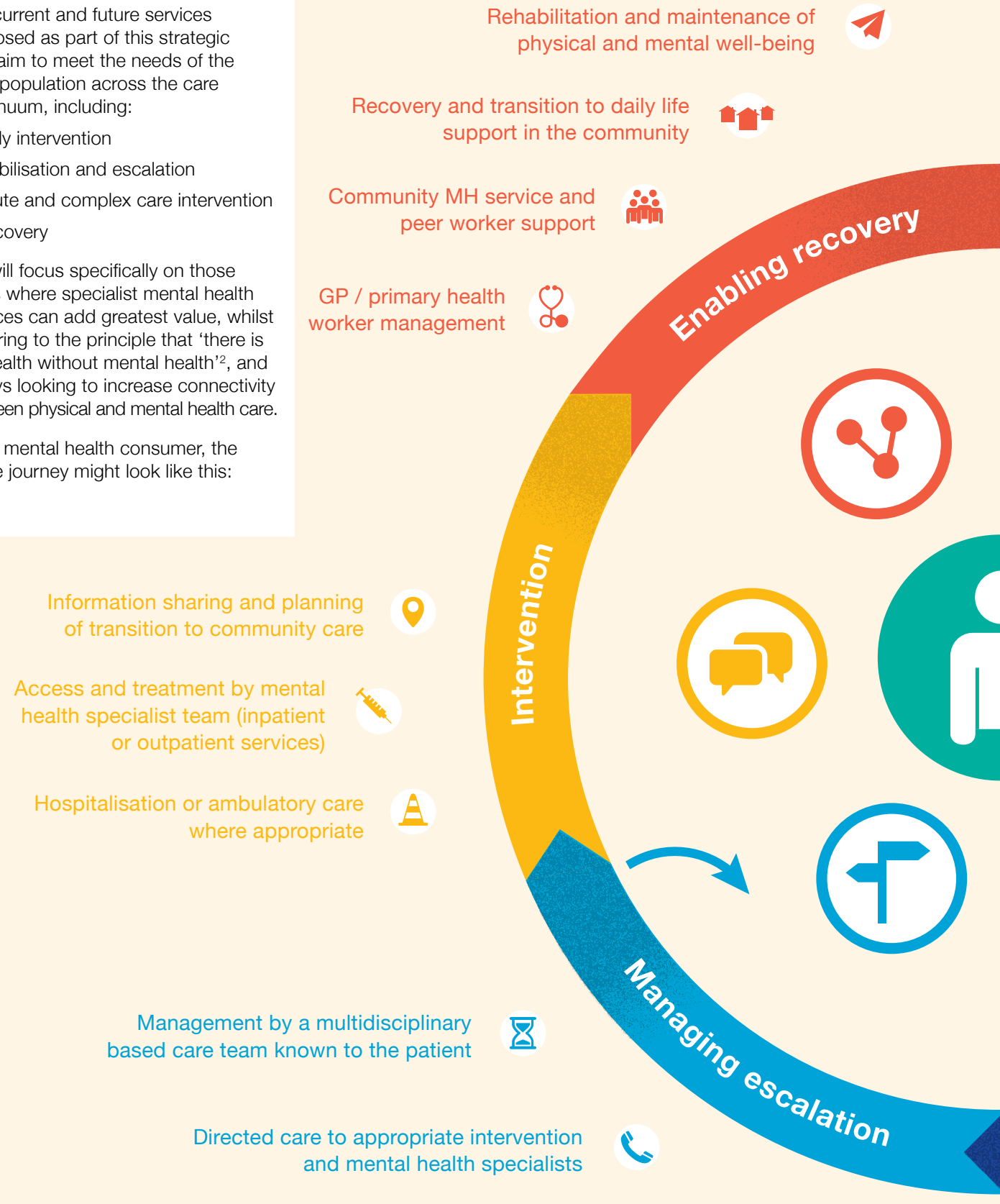
Patient Journey

The current and future services proposed as part of this strategic plan aim to meet the needs of the local population across the care continuum, including:

- Early intervention
- Stabilisation and escalation
- Acute and complex care intervention
- Recovery

We will focus specifically on those areas where specialist mental health services can add greatest value, whilst adhering to the principle that 'there is no health without mental health'[2], and always looking to increase connectivity between physical and mental health care.

For a mental health consumer, the future journey might look like this:



Resources and referral for mental health wellness and education support available online

Education campaigns via our digital platform and community partnerships

Information and support for patient and caregiver network through the Urban Health Centre and PEIPD services

GP assessment for diagnosis and early intervention on-site or nearby

Self-care and online programs through CRUfAD

Transitional services and mental health plan, including navigation for complex needs

Initiation of medication and supported adherence

Family/caregiver network support and awareness

MH community service support and advice

3.2 Our Priorities

3.2.1 Precision Mental Health

We will provide targeted treatment and care for patients to deliver the best possible outcomes for their individual circumstances. We will increase our focus on precision diagnosis, through better patient assessment, as well as increasing our understanding of neurobiology, and drawing on pharmacogenomics, to tailor treatment in accordance with the evidence base and consumer preference.

Tailored treatments will include personalised care plans for all consumers, which are goal and evidence based, including for example:

- Personalised exercise and wellness programs
- Personalised psychotherapy
- Tailored drug treatment programs and drug titration
- Transcranial Magnetic Stimulation
- Electro-convulsive Therapy
- Deep Brain Stimulation.

3.2.2 Strengthening community-based services

High quality, proactive mental health community services will improve outcomes for mental health consumers, reducing admissions to hospital and improving social and community interaction. Adult community services will be expanded to include Crisis Assessment and Home Treatment in the medium term, with a view to providing a Flexible Assertive Community Treatment model in the longer term, where consumers will be able to access intensive support delivered in the community using a team case-load and Assertive Community Treatment principles, as and when they require it. There will be a much greater emphasis on team-based care, enabling seamless transition between high-and-low-intensity care.

We will work with our community and non-government partners together with the Central and Eastern Primary Health Network to strengthen our community based mental health services providing alternatives to hospital based care.

The crisis assessment and home treatment team will provide crisis mental health assessment for adults who require an urgent response and are likely to require the support of the adult community or inpatient mental health services. This team will also provide short-term follow-up for new users and home based treatment as an alternative to hospital admission for existing users of the community health team. Extended hours will enable more people to be supported at home, reducing the pressure on inpatient services. The adult community team will work closely with the PECC and new PACER program to provide a seamless experience for consumers.

The Older People's Mental Health Service will need to expand to meet the emerging varied and increasingly complex needs of Inner Sydney's growing ageing population.

We will also look to expand our successful USpace program, to provide access to more young people across Australia who require specialist mental health support, including inpatient and outreach services. As part of this, we will explicitly consider opportunities to address unmet need in supporting individuals with Eating Disorders.

3.2.3 An Urban Health Centre

The needs of an urban population are unique and different – we will develop an Urban Health Centre to meet the physical and mental health needs of adults (public and private) in our catchment with, or at risk of, mental ill health. We will reorganise and expand our existing outpatient and day-based programs to deliver an early intervention approach that seeks to promote community health support, and a triage model to guide services outwards to the community where appropriate.

The Urban Health Centre will be a central extended hours 'hub' to support and facilitate better access to services for consumers who are at risk and/or have a mental illness, designed to cohort patients into similar groups and provide a safe, welcoming environment for all. The Urban Health Centre should facilitate access for both public and private services in order to ensure provision of care for a wide variety of patients. The centre will include:

- Access to telephone advice 24/7 and support and advice for families and carers
- An information hub with comprehensive information about the relevant services in the area (tertiary services, community health, primary care support etc.)
- Clinical services and counselling, including psycho-social support for those persons that are at risk of experiencing an episode of mental illness or condition is deteriorating
- Access to specialist mental health clinicians on-site
- Triage and referral to community services, GPs and other support services and GP clinic, or GP supervised nurse practitioner, available for immediate assessment (physical and mental)
- Rotating community pharmacists, social workers, psychologists, dental technicians, podiatrists, CSO staff, home economics educators and peer support workers
- Access to programs including online, individual and group programs in a non-hospital based setting (day-based programs such as DBT, tailored programs etc)
- A range of evidence based individual therapies
- Peer led support groups and follow-up
- Opportunities for community based participatory research and other translational research
- Bespoke education services for clinicians and other mental health professionals

Development and operation of an Urban Health Centre will require a suitable location, capital expenditure and ongoing resourcing. Consequently, a business case with cost-benefit analysis, and identification of funding sources and partnerships is required

3.2.4 Digital Mental Health

Evidence based digital mental health offerings will enhance existing services, providing blended care and easy access for consumers, caregivers and clinicians. We will expand the current CRUfAD offering to a wider range of e-health interventions across our patient cohorts. This will include testing and evaluating new and innovative e-health interventions, as well as driving greater uptake of our existing offerings and tailored EHAT modules across the campus and to new populations. We will explore partnerships with Private Health Insurers to drive further uptake, and with digital innovators to develop new digital models of care, including chat-based platforms.

We will scale and expand our highly valued clinician-to-clinician Psychogeriatric SOS service, to further expand reach and coverage of the existing service and roll out the model to other service areas (including providing support for local GPs). As part of this, we will need to develop a sustainable recurrent funding model for the service.

We will seek to establish a common platform to provide a holistic digital mental health offering across the campus. Enabling the sharing of patient information, including outcomes data, across the campus, and beyond, will be critical to continuous improvement in the mental health services. This has not been addressed as part of this Strategic Plan, as it is contingent on the outcome of decisions regarding the future EMR for the Campus.

3.3 Other Service Developments

3.3.1 Strengthening consultation and liaison services

Consultation-Liaison (CL) Psychiatry is a subspecialty of psychiatry that promotes the recovery and wellbeing of people with mental illness or distress who are, or appear to be, medically ill. Practitioners in consultation-liaison provide mental health expertise, advocacy and advice for such people within the general medical setting. The current CL service at the public hospital also provides specialist services to State-Wide services, including most notably in transplantation services, which has well established pathways of care and comprehensive care provision.

There are, however, gaps in provision across the campus and different models of care across public & private hospitals. We will therefore look to develop a consistent and comprehensive consultation liaison offering across public and private hospitals, to ensure that inpatients get access to consistent, high quality consultation liaison services that are tailored to their acute care pathway and personal needs.

Where patients are travelling from further afield for specialist medical care, we will develop a virtual care approach, drawing on the capabilities from our Psychogeriatric SOS program.

Consultation and Liaison services will also take a lead role in championing integrated care across the campus, bringing mental health and care services to physical health care and vice versa.

3.3.2 Care coordination for complex patients

Patients with a dual diagnosis and those with complex needs (mental and physical health) are not best served by the current system. Building on the current Complex Needs Committee, we will establish a care navigator role that will involve delivering complex care plans and supporting patients in accessing the specialist services they require, as well as connecting them to appropriate non-specialist community based programs. As part of this, partnerships will need to be built with existing NGOs to assist with servicing these patients in the community.

Patients will be identified through referral from St Vincent's clinicians, and analysis of activity data to identify those who are frequently attending multiple services.

3.3.3 Prevention and Recovery Care (PARC)

The PARC will provide short-term accommodation, clinical support and therapeutic interventions for consumers who do not require acute inpatient services, but are too unwell to be treated in specialist community services. It provides a step-up, step-down service for consumers requiring lower acuity specialist intervention, including accommodation, and an opportunity for participants to build on gains made in inpatient treatment, or for people in early stages of crisis to access additional support to avoid a hospital admission.

Patients will stay for a minimum of 7 days, up to a maximum of 28 days and have access to a consultant psychiatrist and registrar. Evidence-based individual psychotherapy will be a key tenet of care. It should be noted that in order to deliver this service a suitable space and capital funding will be required.

3.3.4 PACER

The Police, Ambulance and Clinical Early Response (PACER) model has been introduced across various Australian states and is currently being piloted in areas of NSW. It is a model that is predicated on inter-agency cooperation and seeks to support consumers by providing an early intervention service in times of mental health crisis. The service has been shown to improve patient outcomes, and would likely complement the set of services outlined in this document. Subsequently, St Vincent's is seeking to work closely with those operating the PACER pilot and being involved in the program's broader rollout.

3.3.5 Consistent care pathways

There is a need improve standardised care pathways across the campus (both public and private), for all conditions, based on published evidence of what works. This will include greater consistency in our approach to assessment and outcomes measurement, and standardised treatment protocols for patient cohorts and sub-cohorts.

3.3.6 Suicide Prevention

We have been running our Green Card Clinic for over 15 years, for people presenting to the ED with suicidality, which provides 3 sessions to either deal with crisis issues or work out what is needed longer term. Patients are then referred on to suitable primary or specialist services, including potential referral to SP Connect (in partnership with Neami, an NGO).

We will continue to raise awareness of the Green Card Clinic and explore opportunities to refer, and expedite referral, of patients to supportive community services such as SP Connect.

3.3.7 Borderline Personality Disorder

We will look to reinstate the Dialectical Behaviour Therapy program, which was established 2 years ago to support patients with Borderline Personality Disorder, but is not currently operating. We will also explore options to extend the reach of this service to address unmet need, including through exploring opportunities to deliver the service at Parklea correctional facility.

3.4 Enablers

3.4.1 Mental health education

We will create a renewed focus on education to upskill our workforce, and our local community, to deliver better care and outcomes for patients, families and caregivers as well as making them feel empowered and motivated in their day-to-day work. Focusing on these areas is likely to deliver significant benefits to St Vincent's across a number of areas including funding, recruitment, research and delivery of clinical care.

This focus on supervision, education and professional development of our workforce will include:

- Clinical supervision
- Student placements and providing high quality teaching to aspiring mental health clinicians
- Structured programs of formal and informal education for St Vincent's staff including clear pathways for professional progression and formal postgraduate education
- Informal education for NGOs, GPs, police, ambulance, consumers, caregivers and the wider community on a range of topics
- Easy access to online support and teaching programs
- Easy access to information regarding services available mental health
- Peer-led, co-designed and co-produced learning
- A focus on trauma informed care, strengths based model and recovery
- Education in family based therapy.

As part of this program, it is necessary to establish dedicated roles that would be focused on developing, implementing and managing specific initiatives related to supervision, education and professional development.

Our education and training programs will include a number of key principles throughout, including:

- Trauma Informed Care
- Strengths-based care and therapy

Figure 3

Educational Framework

Programs	Medical	Nursing	Allied Health	Peer Workers	Community Partners	Consumers & Carers
Postgraduate courses & placements		■	■			
Enhanced supervision & development	■	■	■	■		
Professional progression pathways	■	■	■	■		
Evidence based family therapies	■	■	■	■	■	
Evidence based individual therapies	■	■	■			
On-line support and programs	■	■	■	■	■	■
On-line information	■	■	■	■	■	■

- Modelling behaviours that lead to a better experience for consumers, carers and families

The Centre for Family Based Therapies will play a key role in providing education and implementation support for evidence-based family therapies.

3.4.2 Research excellence

The opportunity for us to embed ourselves as a leading influencer and thought leader and remain at the forefront of best practice medicine can be achieved through pursuing opportunities to integrate research and education throughout our mental health services.

Our campus has a national and international reputation for clinical research and we are co-located at the site of a major research precinct with established partnerships with a number of world-renowned researchers and Universities specialising in mental health.

We will appoint an Academic Leader for mental health research, as a joint University appointment to drive a coordinated program of research aligned to State and National Priorities. This program will focus on ensuring that the suite of disciplines and services deliver research that meets our vision and furthers the organisation's Mission.

We will also establish a research coordinator position to work across both public and private to develop research partnerships, identify research and funding opportunities, focus the scope of the research portfolio and build upon a diversified and sustainable funding base.

3.4.3 A focus on patients, their family and caregiver network

We are committed to the provision of patient-centred care where patients, their families and caregiver network are actively involved in, and at the centre of, treatment decisions. Families and caregivers play an important role in patient support and care in Mental Health in both the in-and outpatient setting. Many of our current mental health services seek to actively involve families and caregivers in care, but this is not currently done consistently or systematically.

The aim of this strategic plan is to incorporate the family and caregiver network (where suitable and with consent) in patients' care and treatment, and communicate with them at every point in the patient journey.

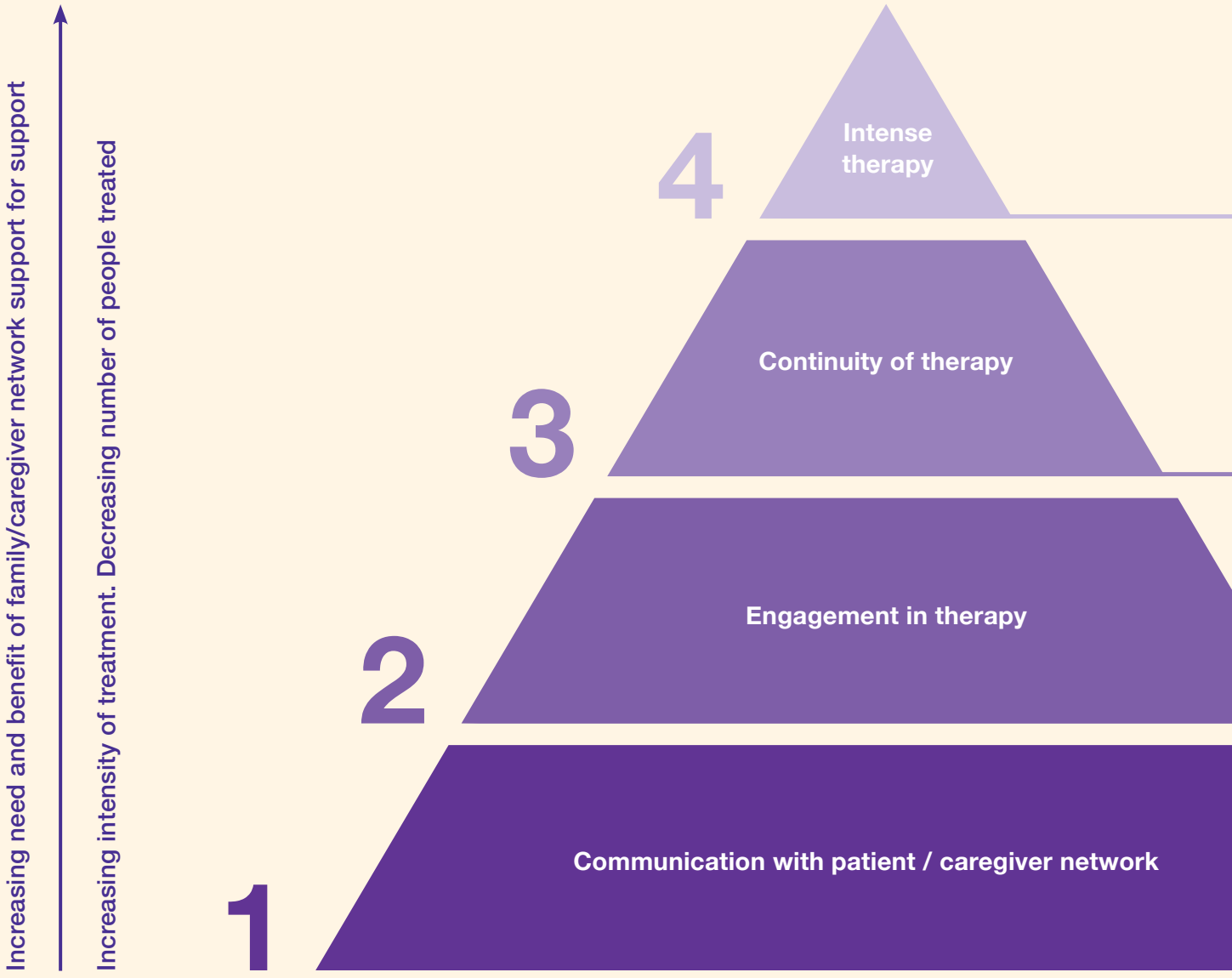
We have developed a needs-adapted and resource-oriented approach that mobilises and includes a patient's psychosocial network, to promote social inclusion and personal autonomy. This approach can be tailored to the individual, and the principle of including the family/caregiver network incorporated, from initial assessment through to the option of increasingly intense therapy, for example, immersive Open Dialogue where maximum benefit to select patients and their network is to be gained.

Culturally appropriate services and care will also be a key feature of our services, to improve access and engagement with hard to reach communities, including aboriginal people, who experience higher levels of mortality and morbidity from mental illness.

A critical success factor in delivering services that truly meet the needs of our consumers and their family & caregiver network, is to involve them in the design of any new services. Co-design will be an integral part of our approach to all aspects of service design.

Figure 5

Approach to patients, their family and caregiver network



- Intensive, evidence-based family/network therapy program for those with the greatest need

- Multiple clinical sessions based on individual response to therapy
- Sessions involve family/caregiver network and are needs based

- Family/caregiver attends initial clinical consultation meeting (where consent has been given)
- Treatment (including family/caregiver support) agreed during session

- Family/caregiver network identified for **all** patients and consent sought for their involvement (if appropriate)
- Links to ongoing MH support and information provided

Note: Intense therapy may include evidence-based therapies such as CBT, IPT, DBT and psychodynamic psychotherapies as well as models such as Open Dialogue, Green Card Clinic, Optimal Health Program and Systemic Family Therapy.

To deliver on this approach will require a program of work, including practical changes to service delivery (such as incorporating family and caregiver network assessment into all of our assessments) and a program of education for our staff to give them the skills and capabilities to involve consumers, families and caregivers in the design of services and in clinical care, and to provide family based therapy where required.

We will also need to ensure our mental health services play an active role in the delivery of the SVHN Aboriginal Health Plan.

3.4.4 A focus on outcomes

There is a need to develop a consistent set of clinical and social outcomes to measure across our services, as well as consistent tools for measurement, and to audit our results regularly. The national indicators from the Fifth National Mental Health Plan provide a helpful framework, which includes:

- Optimising physical and mental health outcomes
- Supporting a meaningful and contributing life, including employment
- Consumer, family and caregiver experience
- Minimising avoidable harm
- Removing stigma and discrimination.

3.4.5 Philanthropy

St Vincent's has a strong tradition of using philanthropy as a means of furthering its mission and in supporting specific initiatives in mental health, including The Centre for Family Based Mental Health Care, funding to support the establishment of the Prevention and Recovery Centre (PARC), Caritas service environment, USpace peer support worker and digital mental health innovations.

There is opportunity to build on this success further and align philanthropic initiatives to the priorities within this plan, through the St Vincent's Curran Foundation developing a funding plan linked to the priorities we have set out.

3.5 Strengthening Community Impact through Partnership

Existing partnerships and working relationships in the community help to develop and enhance a collaborative system of care. These relationships support the building of skills and capacities of service providers, assist members to gain familiarity and develop a stronger sense of commitment and expectation for collaborative behaviour throughout the mental health system.

There are a large number of partners working to improve outcomes for patients with mental ill health in our local catchment area, across education, NGO, health and human services sectors. Many of the services provided by these partners are overlapping, with the potential to complement and support one another, but also to cause confusion for consumers, families and caregivers.

There have been previous attempts to bring these partners together, including the Community Partnerships Program, and subsequently the Urban Partnership, which brought 22 community partners together in pursuit of shared services and objectives. Both of these relied heavily on individuals within St Vincent's Mental Health services to drive progress, and the Urban Partnership has ceased since these individuals have left the service.

Whilst St Vincent's will be a key player in any future community partnership, it is important that it is established on a more formal and self-sustaining footing. We will commence discussions with the previous partners from the Urban Partnership, to test their appetite for a renewed community partnership, and options to make it self-sustaining, including cash and in-kind contributions to fund the infrastructure required.

4 How to get there

4.1 Our Future Workforce

Essential to the delivery of the mental health strategy is a sustainable workforce, with the right clinical expertise, organised around the consumer and their family, so that they experience a seamless journey under the care of a single team.

The core strength of our service is our dedicated and skilled staff, who are currently under substantial pressure due to a shortage of skilled workforce. Our implementation approach to this strategic plan therefore needs to deliver three key workforce objectives:

- Delivery of a sustainable core workforce
- Embedding a vibrant and supportive culture
- Developing the new skills and roles required for the workforce of the future

Development of a workforce plan that meets these objectives requires some further analysis and input by the service, which should be taken forward as a matter of priority, as the remaining elements of this strategic plan are contingent on addressing this critical issue.

Multiple implementation pathways are required (as summarized in the figure below) to ensure we continue to be a workplace of choice delivering clinical excellence, educational opportunities and world-renowned research outcomes.

4.1.1 New roles

There are significant opportunities to provide support to family and caregivers, and additionally to provide the type of clinical support that will allow clinicians to re-allocate their time into other important activities.

Expanded roles for nurses and allied health

We will expand the current assessment capabilities of mental health nurses allied health practitioners, and support Nurse Practitioner (NP) roles to supplement and enhance our current services, and provide a sustainable and effective approach to the rising prevalence of poor mental health. We will explore the full range of opportunities for extended scope of practice, including:

Figure 6

Summary of workforce initiatives

- An early pilot in nurse-led assessment in our adult inpatient unit
- A nurse-practitioner model for supporting complex care patients
- A nurse-practitioner model for older people in primary care and residential aged care facilities
- Criteria led discharge from our PECC and inpatient units.

Peer worker teams

Peer workers are already part of the mental health service at St Vincent's Darlinghurst, with roles supporting the inpatient, ambulatory and community health teams. We will expand the roles of peer workers to be further integrated into the multidisciplinary health care team, with a focus on recovery and patient-centred care. The provision of social support and education by our peer workers will aim to raise awareness and reduce stigma surrounding mental illness within the local community.

We will organise an education session for our clinicians in October 2018 to learn more about peer-led models of care and how our new peer-led workers can support and enhance our services.

Attract and retain talent

We will attract and retain the brightest staff and leading researchers through providing unique research and education opportunities that provide continuing professional development and career advancement.

4.2 Revenue and Funding

We will pursue new avenues of revenue and funding to deliver effective, value-based care to meet the needs of our local population.

There are known deficits in mental health funding nationally in relation to the growing need for services. In 2014-15, mental health received around 5.25 per cent of the overall health budget while representing 12 per cent of the total burden of disease.[3,4]

A number of funding avenues exist for Mental Health and include Government, corporate and industry, philanthropic and charitable, research, and not for profits.

We see several opportunities to pursue these funding initiatives through research and partnership coordination across campus and more broadly, that align with the priorities of Primary Health Networks and the Commonwealth and State governments. Current priorities include:

- Prevention and early intervention
- Underserved populations (children and young adults; older persons; Aboriginal and Torres Strait Islander)
- Suicide prevention
- Severe and Complex Mental Illness
- Digital innovation

We will undertake a program of work to ensure that the funding for mental health services enables us to deliver against this strategic plan. This will include:

- Improving the transparency and governance of mental health revenue and expenditure to ensure the implementation of the Strategic Plan and those funds allocated for mental health are quarantined and delivering cost-effective services.
- Establishing a formal process to identify all opportunities to capture additional State government funding through ensuring all activity based funding eligible services are being captured and complexity of care documented and reported accurately, as well as reviewing all possible sources of Medical Benefits Scheme funding in the outpatient setting and through the delivery of telemedicine opportunities.
- Conducting a review of any potential public – private opportunities to share services and staff to improve efficiencies and delivery of services. This will include exploring opportunities to streamline governance of public/private mental health services.
- Employing a research program coordinator to institute a coordinated and translational research agenda and identify grant, funding and other partnership opportunities for SVMHS.

Figure 7

Summary of funding opportunities

4.3 Implementation Governance

We will establish an appropriate accountability and governance mechanism to oversee the implementation of the Strategic Plan.

Alignment of this Strategic Plan with other St Vincent's reform activities, and creating the governance mechanisms through which to deliver the plan, are essential components of the future success of our mental health services. We will achieve this through the following immediate actions:

- Establishing a Steering Committee to meet quarterly to oversee and guide the activities of the working group responsible for implementation of this plan. The Steering Committee should consider membership from both public and private representatives from finance, information technology services, partnership programs, clinical, medical and human resources.
- Establishing an operational working group that meets fortnightly. This working group brings together the individual service initiative teams responsible for specific tasks and ensuring implementation of the service initiative within specified timelines.
- Identifying a dedicated program manager and supporting resource to drive delivery against our plan.

The Roadmap: Putting Strategy Into Action

Delivering against our vision		2019	2020	2021
Implementation Governance				
Implementation Governance	**The Chief Executives of St Vincent's Public and Private Hospitals Sydney will:** • Establish a steering committee to guide and advise implementation of the strategic plan • Establish an operational working group with day-to-day responsibility for delivery of this strategic plan • Confirm the funding environment and establish the approach for investment allocation for these initiatives • Appoint a program manager to provide administrative and content support and oversee implementation process. Position to be time bound for implementation phase			
Our Priorities				
Precision medicine	**A Lead Clinician and the Strategy & Planning Team will:** • Establish a working group of both Private and Public Hospitals to discuss and define priorities for precision medicine in Mental Health • Sit on the campus-wide Precision Medicine sub-committee • Develop a set of precision mental health service offerings			
Strengthening community-based services	**The Community Services Manager will:** • Develop a business case for the introduction of Crisis Assessment and Home Treatment services • Identify and implement opportunities to provide an improved and seamless experience for consumers, including increased responses to the YES survey • Liaise with the CESPHN to jointly plan and develop primary health mental health services as alternatives to hospital based care **The Older People's Mental Health Lead Clinician will:** • Develop a service plan for the expansion of services to meet the expanding needs of the ageing population, including opportunities to develop new services to support private patients **The Lead Clinician for USpace will:** • Develop a service plan for the expansion of services to meet the future needs of young adults requiring specialist mental health support, including opportunities to develop new services to support public patients and address unmet need in eating disorders			
An Urban Health Centre	**The Program Manager will:** • Identify the appropriate scope of services for inclusion in the Urban Health Centre, through review of the evidence base and consultation with key partners, including City of Sydney			

Delivering against our vision		2019				2020				2021			
	• Develop a program plan for the Urban Health Centre, including: – Feasibility testing for the centre, including a review of funding and capital options – A short-term plan to deliver those elements that can be implemented within existing funding and infrastructure – A medium-term plan to deliver those elements that can be implemented within existing infrastructure but require additional funding – A longer-term plan to deliver the full centre • Liaise with key community partners to establish the range of services that can be provided by partners under each time horizon • Submit the plans for endorsement to the Steering Committee • Deliver against the plan												
Digital Mental Health	**The Lead Clinician for Older People's Mental Health, CRUfAD Lead Clinician and Lead Clinician for Consultation Liaison will:** • Enable and promote the scaling of the psychogeriatric SOS services across the campus • Make existing CRUfAD eHealth interventions readily available to all mental health services on the campus • Identify and prioritise opportunities to drive digital mental health innovation through partnerships (e.g. new models of care and chat-based platforms)												
Other Service Developments													
Strengthening consultation and liaison services	**The Lead Clinician for Consultation & Liaison (Public) and Lead Clinician for The Clinic (Private) will:** • Build on the service models already developed, to establish the service specification for high quality and consistent CL services across the Public and Private Hospitals • Incorporate virtual care delivery into the service model • Develop a workforce plan for the additional CL staff required to deliver the model, underpinned by a business case for the additional revenues (with support from finance) • Implement the principles set out in this plan to include mental health in physical health pathways • Identify practical approaches to champion integrated care across the campus												

The Roadmap: Putting Strategy Into Action

Delivering against our vision		2019				2020				2021			
Other Service Developments													
Care coordination for complex patients	**The NUM for PECC will:** • Conduct an assessment of impact, needs and definition of current frequent users / complex care patients as part of current Complex Care Working Group • Develop a plan for Complex Care Coordinator(s) / Navigators(s) to provide both inpatient / outpatient support • Subject to Steering Committee approval, implement the plan												
Prevention and Recovery Care (PARC)	**The Mental Health Service Manager will:** • Progress the PARC Business Case • Be accountable for detailed planning and implementation once the business case has been approved												
PACER	**The Mental Health Service Manager will:** • Proactively pursue the NSW State government opportunity to participate in the pilot program												
Consistent care pathways	**A Lead Clinician will:** • Establish a virtual working group for the development and testing of new treatment pathways and protocols • Conduct a review of current private and public care pathways and protocols against best practice • Prioritise the pathways and protocols to be standardised • Implement an initial standardised set of protocols and pathways												
Borderline Personality Disorder	**A lead clinician will:** • Reinstate the Dialectical Behaviour Therapy program • Develop plans for implementation of DBT at Parklea												
Suicide Prevention	**The Clinical Lead for Consultation and Liaison (public) will:** • Continue to raise awareness of the Green Card Clinic and explore opportunities to refer, and expedite referral, of patients to supportive community services such as SP Connect												

Delivering against our vision		2019				2020				2021			
Enablers													
Mental health liaison and education	**Cross-discipline leads, including a medical lead, allied health lead, consumer lead, the Director of Nursing and the Professor of Mental Health Nursing will:** • Establish a cross-discipline working group to develop the formal and informal education outlined in this strategic plan												
Research excellence	**The Clinical Director for Mental Health Services (Public) will:** • Progress the appointment of an Academic Lead for mental health research, who will: – Establish a research committee to focus the scope of research and promote collaboration across disciplines – Appoint a research coordinator to work across public and private hospitals to support the research committee and promote partnerships and pursue funding opportunities												
A focus on patients, their family and caregiver network	**The Professor of Mental Health Nursing will:** • Establish a family based education, liaison and treatment team across private and public • Implement the family & caregiver principles set out in the strategic plan, including: – Developing and implementing a standardised approach to assessment – Developing and implementing the education programs required to support clinical staff deliver all elements of the framework												
A focus on outcomes	**The Lead Clinician for Consultation & Liaison (Public) will:** • Implement a service wide review of current outcome measures and benchmark against National and NSW State indicators • Use results of review to develop a consistent and standardised approach to utilise data analytics to drive service delivery and improve patient outcomes.												
Philanthropy	**The Chief Executive of the Curran Foundation will:** • Develop a funding plan linked to the priorities set out within this Strategic Plan, based on the direction of the Steering Committee												

The Roadmap: Putting Strategy Into Action

Delivering against our vision		2019	2020	2021
Strengthening Community Impact through Partnership				
Community Partnership	**The Program Manager will:** • Engage with community partners, including NGOs, other service providers, ambulance and police to establish the appetite for entering into a true community partnership • Support the set-up of a formal and self-sustaining community partnership program			
How to Get There				
The Future Workforce	**The Clinical Director of Mental Health Services (public) will:** • Develop a baseline resource plan for mental health services to deliver high quality, sustainable services • Develop a new model of care for services which organises around the consumer • Develop, with support from the Steering Committee, a recruitment strategy to attract the best talent • Hold a peer workers education meeting across public and private in October 2018, to inform clinicians regarding the potential models of care and opportunities for the peer workforce, and ensure agreements are actioned **The NUM for PECC will:** • Implement pilots for the new workforce models outlined in Section 6.1.1			
Revenue and Funding	**The Director of Integrated Care will:** • Improve the transparency and governance of mental health revenue and expenditure • Establish a formal process to identify all opportunities to capture additional State government funding through ensuring all activity based funding eligible services are being captured			
Philanthropy	**The CEO of St Vincent's Curran Foundation will:** Develop a fundraising strategy to support key priority areas for capital and service development, working with the Director of Integrated Care and the CEO of SVHNS.			

5 Appendix: Supporting Tables & Diagrams

5.1 Performance Data

Indicator	St Vincent's Rank	St Vincent's Value	State Average
YES Results (Ambulatory)	2/18		
YES Results (Inpatient)	3/18		
Clinical Improvement (HoNOS Scores)	20/46	73.9%	73.9%
Length of Stay	27/48	14.8	14.4
28-day readmission	12/18	17%	15%
7-Day Community Follow-up	17/18	59%	73%
Seclusion Rate	5/18	3.6%	6%
Seclusion Duration	4/18	1.7	4.1
YES Completion (IP)	10/18	34%	35%
YES Completion (Community)	11/18	3%	4%

All performance data based on: NSW Ministry of Health InforMH benchmarking Jul-Dec 2017; Interim MoH MH Performance Report Jan-Mar 18; YES Scores 17-18 YTD (to Mar 18). Where data was available from 2 reports, the most recent data was used

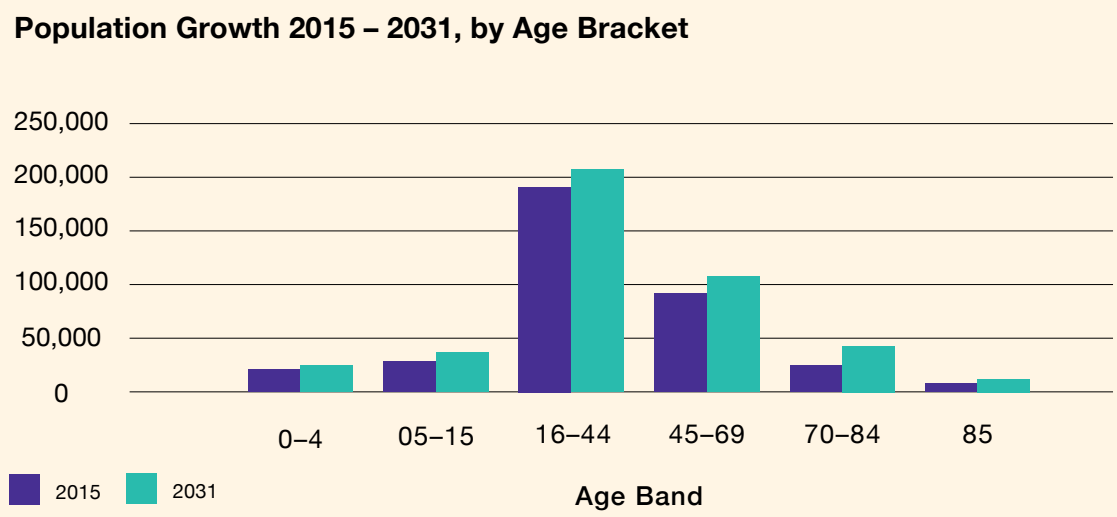
5.2 Primary Local Catchment for Mental Health Services

5.3 Current Activity

Service	Annual Activity [5]	Activity Type
PECC	668	Admissions
Caritas	762	Admissions
CMHT – Referrals	1,376	Referrals
CMHT – Contacts	19,888	Contacts
PEIPOD – Contacts	2,700	Contacts
MH Rehab – Contacts	2,808	Contacts
Psychogeriatrics – Referrals	560	Referrals
Psychogeriatrics – Contacts	7,308	Contacts
Consultation Liaison – Referrals	1,429	Referrals
Consultation Liaison	4,188	Contacts
CRUfAD	364	Referrals
CRUfAD	3,648	Contacts
CRUfAD online	7,000	Referrals
CRUfAD online	11,100	Contacts
USpace	560	Non-Admitted Episodes
USpace	300	Overnight Admissions
Private Clinic	1,080	Appointments

The graph above provides an estimate of annual activity for mental health services across the campus, based on available data

5.4 Population Growth by Age Bracket [6]



5.5 Planning assumptions for Mental Health Services [7]

Service Aspect	Changes to Service Provision
Inpatient activity	• A small increase in acute psychiatric inpatient activity, supporting those complex patients with inpatient care • Expected increase in average length of stay due to: – Early intervention initiatives to prevent ED presentations and subsequent admissions – Less complex patients are increasingly managed in the community
Outpatient / ambulatory care activity	• Slower growth rate in outpatient activity due to: – More care being provided in the community – Improved partnerships with NGOs, primary care, community providers, etc., to support them in managing patients in the community – Less reliance on medication rather than inpatient and residential services – Increased focus on recovery/resilience oriented care and psychosocial interventions – Greater support to patients to self-manage
Catchment	Decrease in out of area presentations to ED, which are currently more than 50% of the total

References: 1. Mental Health Services in Australia, Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary. **2.** Prince, M. et al, 2007, No Health Without Mental Health, Lancet Vol 370, 2007, pp859:877. **3.** https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2014-15/contents/table-of-contents **4.** https://www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/burden-of-disease/overview **5.** Source: KPI Reporting Template Jan – Mar 2018 for all public data except CL, Jul17-Jun18 for CL data directly provided, 17/18 Uspace data and 17/18 Private Clinic data – Dr Fisher data multiplied by 4. **6.** Population estimates from the NSW MoH HealthApp Projections Tool, accessed 21.09.18, including Randwick, Waverley, Woollahra and Sydney (SESLHD) areas. **7.** St Vincent's Integrated Healthcare Campus Darlinghurst Clinical Services Plan 2026/27

ST VINCENT'S HOSPITAL SYDNEY

Mental Health Strategic Plan

St Vincent's Darlinghurst Campus, Sydney

2019 – 2021