Effective Partnership Models: to support a collaborative operational interface between clinical mental health services and the National Disability Insurance Scheme Summary

1. Introduction

This report considers the established mechanisms currently supporting the provision of integrated care and service coordination for mental health consumers through the mental health and NDIS interface, successful models of partnership to support an effective interface between specialist clinical mental health services and the NDIS and discusses the key issues and barriers impacting the establishment of effective partnerships with key NDIS stakeholders to support this service provision.

This report is adapted from earlier work undertaken by St Vincent's mental health staff in related project roles funded by the Victorian Department of Health and Human Services including

- The sector Development Fund (SDF) *Specialist Clinical Mental Health and National Disability Insurance Scheme (NDIS) Collaboration Project.*
- *Inner North West Active Service Model Alliance* Projects
- Primary Care Partnerships *Integrated Care and Service Coordination* innovation projects

1.1 Purpose

The purpose of this report is to summarise issues relating to effective models of partnership to build and support a collaborative interface between mental health services and key NDIS stakeholders.

During co-design workshops conducted with the North East Melbourne Area (NEMA) clinical mental health workforce, consumer and carer peaks and NDIA and LAC representatives, the workforce identified the need to adapt (or create new) partnerships to coordinate supports, address service gaps and meet the needs of those accessing mental health and other support services.

The workforce noted that the approaches used by mental health services prior to the transition to the NDIS, would require some adjustment if they are to continue to function successfully in this new environment as outlined in Table 1.

Table 1 – Partnership arrangements used to support the provision of integrated care and support coordination for mental health consumers

Type of partnership	Level of operation	Key Function	Proposed adjustments to support effective NDIS interface
Stakeholder steering / working group	Steering level	Enabling a coordinated approach to consider, review and progress strategic, system and structural issues.	Requires establishment of a new partnership.
Mental health alliance	Operational level	Providing a forum to support the provision of integrated care and service coordination through communication, shared information and resources, and troubleshooting local level issues.	Reframe alliances to include key NDIS stakeholders including LAC and NDIS funded service providers.
Community of practice	Individual level	Supports the development of local level relationships and information sharing to support and strengthen other forms of partnership.	Develop mechanisms that assist clinicians to build relationships with NDIS, LAC and support coordinators and relevant providers

Building on the outcomes of these workshops, this report considers the impact of the NDIS on these existing partnership structures and identifies the key issues and barriers to effective partnerships in this context.

1.2 Scope

This report addresses the key question raised by the workforce of –

how to work with and relate to a range of new service providers operating in an open market on a fee-for-service basis, after more than 20 years working with block funded disability support services such as mental health community support services (MHCSS) and home and community care (HACC) services.

2. Background

2.1 NDIS and clinical mental health

Mental health services have worked in partnership with block-funded disability support services such as MHCSS' and HACC for over 20 years, to address the psychosocial support and mental health treatment needs of mental health consumers in a coordinated and integrated manner. Achieving seamless integrated care and service coordination for these consumers across a range of sectors and service providers has always been a challenge. Groups working with mental health consumers have long recognised that the particular barriers to engagement experienced by mental health consumers necessitate all service providers to work closely together to address service gaps and achieve improved outcomes for these consumers.

As the NDIS is rolled out and mental health services begin to work with a range of funded service provides, operating in an open market and on a fee for service basis, this will become increasingly challenging. In this changing landscape, the ability to work across sectors and providers in a coordinated approach will become paramount to ensure the ongoing provision of seamless and integrated care for mental health consumers.

2.2 Why are partnerships important?

An effective partnership will harness collective effort, maximise impact and make efficient use of resources through integrated planning, reduced duplication of effort and shared ownership of processes and outcomes[1]. Partnerships are a key mechanism to achieve a more consolidated service approach to address service gaps and to pool resources to meet the needs of those accessing services[2].

This is particularly relevant for mental health services in the changing landscape of the NDIS, who will need to work in a coordinated manner across a range of service sectors and service providers. Mental health services will need to establish robust partnership arrangements to support their engagement with the NDIS[3]. These arrangements should include effective working relationships with key NDIA, LAC and funded service provider staff, and established mechanisms such as working groups, communities of practice or other forums for regular interaction, that enable cooperation and collaboration to ensure the ongoing provision of seamless, integrated planning and coordinated supports, referrals and transitions for consumers.

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[1] The Peninsula Model for Primary Health Planning, 2013.

[2] Victorian Council of Social Services and Victoria Department of Health and Human Services, 2009.

[3] Primary Health Networks (PHNs) are excluded from the scope of these deliverables. The focus of the SDF Project is the interface between mental health services and the NDIS as it relates to consumers who should be or who are eligible for the NDIS scheme.

3. Partnerships

3.1 Types of partnership models

A partnership is described as two or more organisations that "make a commitment to work together on something that concerns both, to develop a shared sense of purpose and agenda, and to generate joint action towards agreed targets"[4]. There are many different types of partnerships that can range on a continuum from networking through to collaboration[5] as outlined in Table 2. Partnerships can be characterised as either formal or informal. Formal partnerships are established deliberately and in a pro-active manner, they have a framework to provide leadership and promote sustainability and usually, some form of funded administrative or project support.

More informal partnerships are often established in response to a specific need or set of circumstances, making them more reactive. They are less structured and tend to focus on information and knowledge sharing. The effectiveness of informal partnerships varies depending on their level of cohesion and the goodwill of the participant members, making them harder to manage and less reliable[6].

Table 2. Continuum of partnerships[7]

Type of partnership	Key characteristics
Networking	Involves the exchange of information for mutual benefit. This requires little time and trust between partners.
Coordinating	Involves exchanging information and altering activities for a common purpose.
Cooperating	Involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, a high level of trust between partners, and an ability for agencies to share turf.
Collaborating	Includes enhancing the health promotion capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system.

Ultimately the particular type of partnership that organisations decide to establish will depend on the need, purpose, willingness and resources of stakeholders to participate in the partnership[8]. Of greater importance than the model of partnership is ensuring there are shared goals and purpose, the right stakeholders are represented in the partnership, and that the member organisations obtain the benefits sought through participation in the partnership.

3.2 Models of partnership used to support the mental health and NDIS interface

As discussed in section 1.1, the co-design workshops held early in the Project identified three models of partnership used by mental health services to support the provision of integrated care and service coordination for mental health consumers including:

- Stakeholder Steering or Working Group
- Mental Health Alliance
- Community of Practice.

[4] Stern and Green, J, 2005.

[5] VicHealth, 2016.

[6] Jane Moreton, Victorian Alcohol and Drug Association (VAADA).

[7] Himmelman, A, 2001 (cited in VicHealth, 2016).

[8] VicHealth, 2016.

These three models also cover a broad span along the partnerships continuum outlined in Table 2, and therefore provide a useful framework for considering effective models of partnership to support a mental health and NDIS interface.

A summary of the three partnership models, their key characteristics and benefits is provided Table 3, followed by a more detailed discussion of each model. Table 3 may be a useful tool for mental health services to quickly identify the type of partnership arrangements they currently have in place and what they may intend to work towards in the future.

Table 3 Overview of partnerships used to support the mental health and NDIS interface

	Stakeholder Steering / Working Group	Mental Health Alliance	Community of Practice
Description	A type of partnership that is generally convened for a particular purpose or project to maintain a common focus between a range of external stakeholders & enable a collective approach to shared issues.	A formal model of partnership that is focused on using the collective effort of providers within a particular catchment area, to address service gaps and agreed priorities to improve service coordination.	A group of people who share a concern, a set of problems or a passion about a topic & who develop their knowledge & expertise in this area by meeting on an ongoing basis[9].
Partnership type (refers to Table 2)	Coordinating / Cooperating (Subject to commitment of members)	Collaborating or coordinating / cooperating (Subject to commitment of members)	Networking
Key characteristics	• Information exchange • Altering activities for a common purpose • With additional commitment - Sharing resources	• Enhancing the health promotion capacity of members for mutual benefit and common purpose (collaborating) • Information exchange • Altering activities for a common purpose • Sharing resources	Information exchange
Formal / Informal	Semi-formal, designated leadership, documented membership, objectives and purpose.	Formal partnership model supported by documented governance structures and management arrangements.	Informal, may have objectives and purpose, generally no power to effect change.
Benefits	• Information sharing • Networking opportunities • Strengthened relationships and improved collaborative practices.	• Supports integrated care & service coordination. • Increased understanding of member organisations • Networking opportunities • Strengthened relationships & improved collaborative practices. • Opportunities to work strategically with cross-sectoral partners. • Supports collective & collaborative learning.	• Information sharing • Networking & relationship building opportunities

[9] Wenger, McDermott and Snyder, 2002 (cited in Mental Health Coordinating Council, 2016).

Stakeholder Steering /Working Group

A stakeholder steering or working group is type of partnership that is generally convened for a particular purpose or project to provide direction, maintain a common focus between a range of external stakeholders and enable a collective approach to shared issues. This kind of group may take the form of a steering group or a working group, dependent upon the seniority of member representatives and other related governance structures. This type of group is a formal model of partnership.

A steering/working group will usually have agreed terms of reference to outline the purpose, objectives and membership of the group, and some form of designated leadership. The group will generally link to other existing governance structures related to the group's purpose.

In terms of the continuum of partnerships outlined in Table 2, a stakeholder steering or working group will function somewhere between the 'coordinating' and 'cooperating' level, and is characterised by information sharing, altering activities for a common purpose and, under some circumstances, sharing of resources.

Mental Health Alliance

A mental health alliance (an alliance) is a formal model of partnership that is focused on using the collective effort of providers within a particular catchment area, to address service gaps and agreed priorities to improve service coordination.

An alliance will usually establish its own independent governance and accountability framework, supported by formal documentation such as a memorandum of understanding. An alliance will also have agreed and documented functions and objectives, membership, and management arrangements.

Having regard to the continuum of partnerships outlined in Table 2, a well-established alliance should function at the 'collaborating' level, providing opportunities to enhance the health promotion capacity of members for mutual benefit and a common purpose, in addition to providing information exchange, altering activities for a common purpose and sharing resources.

It should be noted however that it is not unusual for partnerships that are intended to be alliances to function more around the coordinating or cooperating level, subject to the commitment of partners and availability of resources to drive the partnerships, for example the availability of funded administrative support.

Community of Practice

A community of practice is a group of people who share a concern, a set of problems or a passion about a topic and who develop their knowledge and expertise in this area by meeting on an ongoing basis[10]. A community of practice is a more informal partnership model with a minimal governance structure and generally, no power to effect change. The primary benefit of a community of practice is information sharing and informal networking / relationship building opportunities.

Community of practice membership may be open or closed depending upon the purpose of the group, and whilst an open group is more inclusive it can be more difficult to manage due to increased numbers and a more diverse range of views.

On the continuum of partnerships outlined in Table 2, a community of practice sits around the level of 'networking' with the primary benefit being information sharing and informal networking and relationship building opportunities.

A community of practice is considered too informal and lacking in the necessary governance structures to properly support the mental health and NDIS interface, particularly in regard to enabling the provision of integrated care and service coordination. However, a community of practice is a great structure for

[10] Wenger, McDermott and Snyder, 2002.

establishing and developing relationships that can support and strengthen other forms of partnership, and for sharing NDIS learnings.

A detailed guideline for establishing a Local NDIS community of practice can be found here https://www.mhcc.org.au/wp-content/uploads/2018/05/ndis_cop_guidelines_final_200117.pdf

Preferred model of partnership

The observations around the intent versus the reality of partnership arrangements discussed in regard to alliances and in the case studies included in Attachment 1, demonstrate that labels assigned to a particular partnership arrangement may not always be indicative of the reality of the partnership. Of greater significance are the characteristics and membership of the partnership. For organisations that want a better understanding of their partnership arrangements, VicHealth have developed a partnerships analysis tool that may assist them to assess, monitor and maximise the ongoing effectiveness of their arrangements. This tool can be accessed from https://www.vichealth.vic.gov.au/media-and-resources/publications/the-partnerships-analysis-tool

Regardless of partnership model, ensuring key characteristics associated with collaborative partnerships of mutual benefit, common purpose and shared compromise to improve service delivery are considered most likely to support the provision of integrated care and service coordination required for mental health consumers.

Of particular importance is ensuring the correct membership and characteristics of the partnership to promote its success.

Key partnership stakeholders

The key stakeholders considered essential to a successful mental health / NDIS partnership, that will best support the provision of integrated care and service coordination include –

- Mental health service leader responsible for NDIS readiness, change and/or community collaboration
- NDIA
  Stakeholder engagement director and senior NDIA planners
- BSL
  Senior Local Area Coordinators
- Key NDIS funded service provider managers

3.3 Enablers to partnerships to support the mental health and NDIS interface

A Collaboration Blueprint[11] prepared for the NSW Public Service Commission identifies a range of barriers and enablers that are considered common to and critical for all forms of collaboration (such as partnerships), including a number of barriers that are specific to the public service context as outlined in Table 4. The Collaboration Blueprint notes that whilst the relative importance of each barrier or enabler may vary depending on the scale, form, intent and model of collaboration, ensuring that each is considered and addressed is likely to increase the success of the collaboration.

[11] Nous Group, 2013.

Table 4 – Enablers and barriers to effective collaboration[12]

Enablers	Barriers	Public sector specific barriers
• Trust - organisational and personal • Leadership – strong and effective leadership • Individuals – who can work in partnership with others • Governance – appropriate and adaptable governance	• Power asymmetries • Inadequate accountability and responsibility • Insufficient investment of time, resources and energy • Differences in operating language and culture	• Stringent accountability frameworks that may limit flexibility • A political environment that can change rapidly • The frequent movement of public servants into new roles

3.4 Challenges specific to NDIS rollout and transition

The public sector specific barriers identified in Table 4 are particularly relevant as they are consistent with the issues that have been experienced to date by NEMA mental health services in the evolving NDIS landscape. For example, the environment in which mental health services are currently engaging with the NDIS to support consumers lacks certainty and continuity, has inadequate resource capability, lacks formal escalation and resolution processes and does not allow for the complexities of psychosocial disability as compared with more general disability.

Each of these issues is discussed in more detail below, however these experiences collectively indicate that inadequate consideration has been given to the potential impacts of the NDIS on existing forms of collaboration and partnership used to provide coordinated and integrated care to mental health consumers. They also demonstrate the significant impact on service provision where there is inadequate consideration of and planning to address potential barriers and highlight the urgent need for a coordinated response at a national level to implement strategies that will address these impacts.

Current operating environment

The NDIS is new and continually evolving, this is causing uncertainty and a poor understanding of systems and processes for mental health services, consumers and key NDIS stakeholders such as NDIA Directors of stakeholder engagement. In addition to this NDIA resources are stretched thin, they are responsible for supporting numerous health services, across all disability types, in regard to a continually evolving scheme. The seemingly high turn-over rate of NDIA staff in local level roles may be indicative of this high pressure environment and is compounding the low level of understanding and the difficulties mental health services are experiencing when trying to establish effective relationships to engage with the NDIS.

Escalation processes and issues resolution

The COAG Applied Principles and the Department's RISET document articulate the respective responsibilities of mental health services and the NDIA, however there are no established NDIA processes to escalate or resolve issues when these responsibilities are not upheld.

In addition to this, the current NDIS operating model includes no allowance for the high level of support many consumers with psychosocial disability require from mental health services to effectively engage with and participate in the NDIS. For example, there is no dedicated NDIA mental health counterpart for the clinical mental health workforce to liaise with, making the resolution of issues and provision of integrated planning and coordinated supports, referrals and transitions for shared consumers incredibly challenging.

The lack of escalation processes and equivalent mental health counterparts within the NDIA are compounding the complexities of the current operating environment outlined above. In the absence of

[12] (Adapted from) Nous, 2013.

established structures, effective service coordination and issues resolution is dependent upon the ability of the clinical mental health workforce to make and maintain good relationships with key NDIA staff, and the goodwill of those staff involved. This can be particularly challenging in an environment of high staff turnover, leading to high variability in outcomes depending upon the individuals involved.

This is not an appropriate or sustainable mechanism for escalation and resolution of issues, particularly where they relate to the national rollout of a social reform intended to improve outcomes for vulnerable members of society.

4. Conclusion and recommendations

4.1 Conclusion

The provision of seamless integrated care and service coordination for mental health consumers is a necessity. Without appropriate integration and coordination all aspects of care can suffer, for example patients can get lost in the system, required services fail to be delivered, are delayed or duplicated, the quality of care declines and the potential for cost effectiveness diminishes[13]. Curry and Ham (2010) note there is no single 'best practice' model of integrated care. Rather what matters most is that clinical and other service integration focuses on how care can be better provided around the needs of individuals, particularly in the context of multi sectoral providers.

This highlights the critical role of effective partnerships and collaboration in the mental health and NDIS context, and the importance of understanding and addressing potential barriers that may impact these partnerships. In the mental health and NDIS context service integration and coordination is currently occurring through many different forms of partnership and collaboration, but the effectiveness of this service provision is being impacted by structural barriers inherent in the NDIA's current operating framework.

These issues cannot be resolved at a local partnership level, as they require structural changes to the NDIA's framework for delivery of the NDIS as outlined in the recommendations below and will action at the national level.

4.2 Recommendations

Recommended actions to improve support for consumers shared care and NDIS participation include:

1. NDIA to engage in co-design with clinical mental health and consumer and carer peak bodies to facilitate the establishment of a formal and agreed escalation process for mental health services, where NDIA stakeholders are not upholding their agreed responsibilities.
2. NDIA to support the provision of integrated care and service coordination for shared consumers in by establishing local level NDIA mental health counterparts. This will require the NDIA to understand the significant and necessary role that mental health services have in supporting consumers to access and participate in the NDIS.
3. Mental health services to consider the establishment of communities of practice or other forums to improve information sharing, networking and relationship building opportunities as a means to enhancing other forms of partnership that support the mental health and NDIS interface.

[13] Kodner and Spreeuwenberg, 2002.