Building Capacity Through Delivery Model Redesign; A University Mental Health and General Practice Service Case Report.

Tim Staunton Smith
Senior Lecturer, Department of General Practice
School of Primary and Allied Health Care
Faculty of Medicine Nursing and Health Sciences
Monash University
General Practitioner
Wellbeing at Swinburne
Swinburne University of Technology

Glenda Langford
Associate Director
Wellbeing at Swinburne
Swinburne University of Technology

Background

Despite most young people rating their health positively, significant morbidity is attributable to mental health conditions and risk taking behaviour during these formative years (Australian Institute of Health and Welfare, 2014). This knowledge is mirrored by an enlarging body of research involving university students (who are mostly young) highlighting their psychological distress, complexity of mental health conditions in addition to service gaps and paths forward (Forbes-Mewett, Sawyer, 2016; Larcombe, et al. 2016; Orygen, 2017; Stallman, 2008; Veness, 2016). How Australian universities currently respond to their students' specific needs represents a potential gap in research.

In a recent article published in the Australian Journal of General Practice, the author pointed to the lack of research of Australian university associated general practices while highlighting the youth-centricity of three such practices (Staunton Smith, 2018). Future inquiries were signposted including analysis of university associated general practice structural frameworks and exploring their representation as an additional model of youth-centric healthcare alongside Headspace (McGorry, 2007) and GPs in schools' programs (Kang et al., 2006).

General practice services are only one component of a suite of health services offered by many Australian universities. Other services include health promotion, counselling, psychology, psychiatry, physiotherapy, dietitians and disability support services. In addition, some universities offer supervised student allied health clinics such as physiotherapy, exercise physiology, optometry, dietetics, podiatry and psychology.

Similar to university associated general practices, the structure, integration and governance of the wider suite of Australian university health services appears under-described in published literature. How well the services cater to the needs of their student populations may be reflected in annual Student Experience Survey National Report data (The Social Research Centre [TSRC], 2018). In the 2017 report, there was a positive rating for 'health services and support' of 72.4% and 73% for undergraduate and post-graduate course work students respectively (TSRC, 2018). However, there is marked variation between universities, with positive ratings from undergraduate students ranging between 57.4 and 90.8% (TSRC, 2018).

For universities looking to improve services there is little Australian-centric literature on what makes an ideal service, with much of the work generated in America. America has a long tradition of university-based health services dating back to 1861 and Dr Edward Hitchcock, the first medical director of the Amherst College health service. The expanding field of college health led to the

formation of the 'The American College Health Association' (ACHA) in 1920. The ACHA continues to be the principal leadership organisation for advancing the health of American college students and campus communities through advocacy, education and research.

In 2010, the ACHA published a white paper 'Considerations for Integration of Counseling and Health Services on College and University Campuses' (ACHA, 2010). The white paper recognised the lack of knowledge of integrated medical and counselling services at colleges and universities and called for research to understand motivations and mechanics of such mergers (ACHA, 2010). An article published in 2015 highlighted the trend for American college counselling centres and student health services to collaborate closely, particularly in the face of student cohorts displaying increasingly serious and complex mental health diagnoses (Prince, 2015). The same article emphasises the challenges as not being unique to the United States (Prince, 2015).

In addition to America, Australian universities might look to youth-centric models of healthcare in order to improve their service design. Headspace centres have been proposed as ideal models of youth-centric healthcare (McGorry, 2007) and attracted significant Australian government funding. However, how this investment translates to improved outcomes for Australia's young people is uncertain (Hilferty et al., 2015) and their challenges of recruiting and retaining general practitioners have been highlighted (Barker, 2019). Best practice guidelines are also available for health services wishing to create a youth-friendly health service (NSW Centre for the Advancement of Adolescent Health [CAAH], 2013). These guidelines advocate for youth involvement in their health services (CAAH, 2013).

Further to striving to provide best-evidenced models of care for students, Australian universities and their health services should be aware of monitoring by the Australian Government Tertiary Education Quality and Standards Agency (TEQSA). TEQSA is responsible for ensuring compliance within Australia's tertiary sector with the federal government's Higher Education Standards (HES) Framework. Wellbeing and safety are incorporated within the Learning and Environment domain of the HES framework and include; avenues and contacts for support for students if needed; availability of specific types of personal support services; and, ensuring that support services offered reflect the needs of student cohorts (Australian Government Tertiary Education Quality and Standards Agency, 2018). Minor framework adjustments followed the release of the Australian Human Rights Commission's 'National report on sexual assault and sexual harassment at Australian universities' which urged universities to audit their counselling services (Australian Human Rights Commission, 2017).

With this background in mind, the Show Case report below describes an initiative undertaken by Swinburne University Health Service to service redesign towards an expanded and alternative service delivery model.

Issue the initiative was designed to address

Swinburne University of Technology in Melbourne has three campuses, with the main site located in Melbourne's inner east suburb of Hawthorn. The initiative undertaken principally involves the main campus health and counselling services located in Hawthorn. The services cater to Swinburne University students (domestic and international) and a minority of students from other tertiary institutions, in addition to staff and local residents.

A general practice health service was established at Swinburne's Hawthorn campus 40 years ago with a part time doctor and nurse. A separate counselling service emerged elsewhere on campus at a later date. In 2010, both counselling and the general practice health services moved to be co-located in a purpose built centre on the Hawthorn campus. The two services operated independently with separate management, administration staff, booking procedures and clinical information management systems.

A 2017 internal report commissioned by the Swinburne University Vice President and Director of International Student Services revealed problems meeting the demands and complexity of student presentations to the counselling service. The counselling service was constrained in seeing limited clients in a day, pushing waiting times out to three weeks for regular counselling sessions. A lack of capacity to offer urgent same day counselling appointments added critical time demands to the general practice health service, when distressed students presented in crisis. Interim measures to address this issue had been implemented in early 2017 with Lifeline contracted to offer crisis counselling via a dedicated afterhours Swinburne Crisis Hotline in addition to 2 Mental Health Nurses (MHN) (initially 1, then 2 days a week) funded via the Primary Health Network (PHN) from 2016.

Capacity was also identified as an issue within the general practice component of the health service with prolonged wait times for regular appointments with the general practitioners (3 fulltime equivalent [FTE]), 1 private psychiatrist and 1 private psychologist. Number of clinicians and flow over from the counselling service were flagged as contributors.

Despite being co-located, the report identified siloing of the mental health and general practice components of the health service. Having separate administration, booking in and clinical information management systems were seen as potential areas to integrate.

The report highlighted specific skill shortages within the existing teams including an inability to deal with the wide-ranging and complex mental health presentations together with a lack of allied health services and student involvement in health service operations. Figure 1 illustrates the pre-implementation Swinburne Health Services structure.

Figure 1: 2017 Pre-implementation Swinburne Health Services (Hawthorn Campus)

Desired outcomes

The redesign envisaged an integrated and expanded general practice and mental health service capable of offering care for urgent and continuing needs of health service users. Patients would present to a single administrative point using one registration and billing process. Systems of triage would be developed for mental health and non-mental health presentations allowing urgent access to appropriate staff rostered to triage duty on a rotating basis.

All clinicians within the health service would use a combined appointment system and information management system. Additional allied health services and student involvement were further desired outcomes together with a financial officer and co-location of complimentary external organisations.

Description of initiative

Following the 2017 internal review identifying gaps and desired outcomes, a new model of service delivery was formulated, and a discussion paper circulated. Consultative meetings occurred between report commissioners, general practice and counselling staff. Feedback was incorporated into a final model adopted by the university executive committee three months after the release of the initial

discussion paper. The model was then implemented.

Where appropriate, training was offered to upskill staff members and redundancies or redeployment within the university. The counselling management position was vacated prior to model implementation enabling early recruitment of this position. The new manager was re-titled Counselling and Psychological Service (CAPS) manager to reflect the incorporation of contracted mental health staff into their responsibilities.

With the departure of all six counselling staff, eight MHNs were recruited with a range of clinical expertise and skills including; eating disorders, domestic violence, sexual assault, self-harm, mood disorders, psychosis, Asperger's, PTSD, drug and alcohol, personality disorders, Aboriginal health, LGBTIQ youth, domestic violence, family therapy, CBT, and ACT. The PHN funded MHN program was discontinued. Additional private psychiatrists and a psychologist were contracted and incorporated under CAPS management with the existing mental health contractors and a system of triage developed.

Co-locations for complimentary external organisations were sought and opportunistically embraced including; Eastern Centre Against Sexual Assault (ECASA), Eastern Domestic Violence Service (EDVOS), Access Health and Community Service (alcohol and drug [AOD] counsellor) and a Chinese speaking counsellor. Further general practitioners were recruited, and registered nurses offered additional training. First phase implementation was completed prior to semester 1, 2018 with ongoing implementation throughout 2018 including the student led '*H.squad*' (health promotion activities and student peer support) and allied health services.

Evaluation used or planned

Twelve months after the model was implemented a preliminary review was undertaken with quantitative analysis of numbers of consultations in 2016 compared with 2018, a qualitative staff survey and general review of other desired outcomes. No further formal evaluations are planned.

Table 1 illustrates a comparison in consultation numbers seen by practitioners in 2016 and 2018. Of note is the 245% increase in numbers seen by mental health practitioners - with 5,025 seen in 2016, increasing to 12,339 in 2018. Additionally, there was an increase of 130% in general practitioner consultations.

The anonymous health service staff survey received 26 responses. 25 of the respondents reported a positive reaction to the changes with comments such as;

'Better service'

'Better access for students'

'Better team collaboration'

A single respondent was uncertain of the value of the changes implemented.

The 12-month evaluation identified the information management system as insufficient. Inability to segregate notes, adaptability to mental health cases and constraints on growth were specific concerns and development of a new system commenced with a view to implementation in mid 2019.

Table 1: Total Number of Consultations for Practitioners in 2016 and 2018

Practitioner Type	2016 Consultations	2018 Consultations
<i>General Practitioner</i>	15427	18938
<i>Psychiatrist</i>	622	1559
<i>Psychologist</i>	817	1678
<i>Mental Health Nurse</i>	400	9102
<i>Counsellor</i>	3186	0

Outcomes from this or earlier pilot

The final model is displayed in Figure 2. To illustrate the transition to a more comprehensive and integrated service, a new name ‘Wellbeing at Swinburne’ was adopted.

Figure 2: 2019 Post-implementation ‘Wellbeing at Swinburne’

All patients present to a single administration point, regardless of who they are seeing facilitating service integration alongside a single information management system. Acute presentations are managed through 2 triage pathways for either mental health or non-mental health presentations. Distressed students are seen by MHNs with specific training in acute presentations reducing overflow to general practice services. This, in addition to an increased general practitioner FTE (4 FTE) has improved the ability of general practice staff to deal with acute non-mental health presentations, run to schedule and reduce wait times for routine appointments.

Capacity to see more clients and cope with complex and ongoing mental health conditions has been bolstered by the breadth of MHN skills, the addition of 2 psychiatrists and a second private psychologist. Broadened service delivery has occurred with a contracted physiotherapist and dietitian and co-located ECASA, EDVOS, AOD and Chinese counsellors.

Wellbeing at Swinburne has expanded its reach beyond a single service location with ‘*H-squad*’ alongside ongoing health promotion. ‘*H-squad*’ is providing an opportunity for student involvement with the health service.

This show case report has described a capacity building initiative through service model redesign at Swinburne University of Technology’s Hawthorn campus health service in 2017 and 2018. The redesign was informed by a review process identifying areas for improvement and fits with the research landscape describing some of the challenges and responses of universities and their students to maintain and promote health and wellbeing in Australia and the United States. The report may be of interest to other Australian universities and their health services contemplating redesign, in addition to researchers looking at models of youth-centric healthcare. The function and integration of additional student services (e.g. student led allied health clinics) both at Swinburne and other Australian universities are potential future lines of enquiry.

References

- American College Health Association (2010). *American College Health Association consideration for integration of counseling and health services on college and university campuses*. Retrieved from https://www.acha.org/documents/resources/guidelines/ACHA_Considerations_for_Integration_of_Counseling_White_Paper_Mar2010.pdf
- Australian Government Tertiary Education Quality and Standards Agency (TEQSA) (2018). *Guidance note: Wellbeing and safety*. Retrieved from <https://www.teqsa.gov.au/sites/default/files/guidance-note-wellbeing-and-safety-v1-2.pdf?v=1515375436>
- Australian Human Rights Commission (2017). *Change the course: National report on sexual assault and sexual harassment at Australian Universities 2017*. Retrieved from https://www.humanrights.gov.au/sites/default/files/document/publication/AHRC_2017_ChangeTheCourse_UniversityReport.pdf
- Australian Institute of Health and Welfare (2014). *Australia's health 2014: In brief*. Cat. no. AUS 181. Canberra, Australia: AIHW. Retrieved from <https://www.aihw.gov.au/getmedia/d2946c3e-9b94-413c-898c-aa5219903b8c/16507.pdf.aspx?inline=true>
- Barker, S. (2019). The importance of having general practitioners in youth services. *Australian Journal of General Practice*, 48(3), 87.
- Forbes-Mewett, H., Sawyer, A. (2016). International students and mental health. *Journal of International Students*, 6(3), 661-677.
- Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., ...Katz, I. (2015). *Is headspace making a difference to young people's lives? Final Report of the independent evaluation of the headspace program*. (SPRC Report 08/2015). Sydney, Australia: Social Policy Research Centre, UNSW. Retrieved from <https://headspace.org.au/assets/Uploads/Evaluation-of-headspace-program.pdf>
- Kang, M., Bernard D., Usherwood T., Quine, S., Alperstein, G., Kerr-Roubicek, H., ... Bennett, D. (2006). Primary health care for young people: Are there different models of service delivery that improve access and quality? *Youth Studies Australia*, 25:49-59.
- Larcombe, W., Finch, S., Sore, R., Murray, C.M., Kentish, S., Mulder, R.A., ... Williams, D.A. (2016). Prevalence and socio-demographic correlates of psychological distress among students at an Australian university. *Studies in Higher Education*, 41(6):1074-1091.
- McGorry PD (2007). The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Medical Journal of Australia*, 187:53.
- NSW Centre for the Advancement of Adolescent Health (2013). *Youth friendly general practice training toolkit*. Sydney, Australia: NSW CAAH.
- Orygen (2017). *Under the radar. The mental health of Australian university students*. Melbourne, Australia: Orygen, The National Centre of Excellence in Youth Mental Health. Retrieved from https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Under-the-radar/Orygen-Under_the_radar_report.aspx
- Prince, J.P. (2015). University student counseling and mental health in the United States: Trends and challenges. *Mental Health & Prevention*, (3), 5-10
- Stallman, H. (2008). Prevalence of psychological distress in university students: Implications for service delivery. *Australian Family Physician*, 37: 339-341.
- Staunton Smith, T. (2018). The Youth Centricity of three university associated general practices. *Australian Journal of General Practice*, 47(8):541-544.
- The Social Research Centre (2018). *2017 Student experience survey national report*. Retrieved from https://www.qilt.edu.au/docs/default-source/ues-national-report/2017-student-experience-survey-national-report/2017-ses-national-reportb27e8791b1e86477b58fff00006709da.pdf?sfvrsn=1e96e33c_2
- Veness, B.G. (2016). *The wicked problem of university student mental health*. Report to the Winston Churchill Memorial Trust, Sydney Australia. Retrieved from https://www.churchilltrust.com.au/media/fellows/Veness_B_2013_The_wicked_problem_of_university_student_mental_health.pdf

The authors may be contacted via:
timothy.stauntonsmith@monash.edu

Please cite this paper as:

Staunton Smith, T. & Langford, G. (2019). Building capacity through delivery model redesign; A university mental health and general practice service case report. *Journal of the Australian and New Zealand Student Services Association*, 27(2), 236-242. <https://doi.org.10.30688/janzssa.2019.07>