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Service Delivery

Integrated service delivery is formed around the principles of **continuity of care** between screening, primary and mental health treatment services. This may mean services are managed and/or provided by **one organisation/health service**. It may also involve **supported transition and seamless referrals** (i.e., proactively and personally linking young people with internal or external services and organising appropriate discharge) as discussed below (Hodgins et al., 2022). Please use **2b Checklist** to guide you through possible action items described below.

Stratified care

Providing **access to the right care** early in the course of illness is a critical step towards reducing these service gaps. Key action points from Australia's national health reform relates to greater integration of personalised care matched to individual's needs at point of entry into the healthcare system. **Stratified care** is defined as an evidence-based, integrated care system comprising of a hierarchy of service levels, from the least to the most intensive (Figure 1). The aim is to match intensity of care according to individual's immediate and changing needs through stepping-up and stepping down individuals through different service levels.

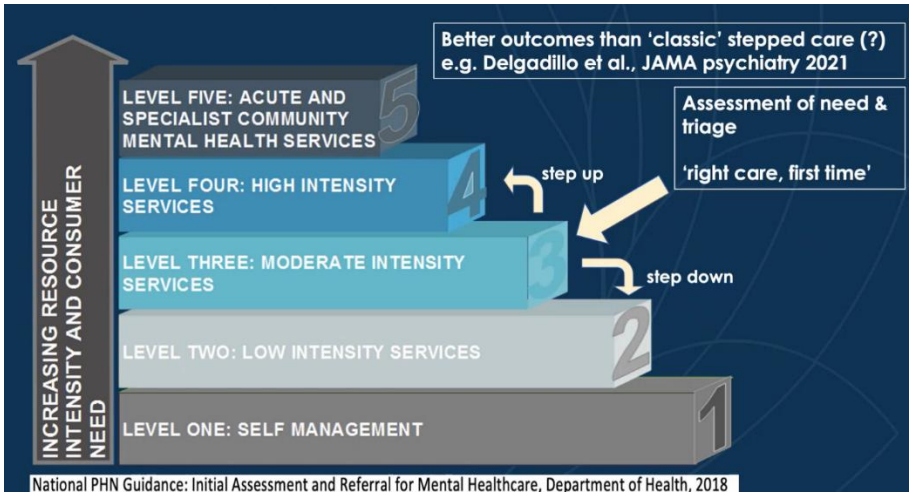

Figure 1: Mental health services in Australia, Stratification by service intensity

When a young person enters the system, it may be helpful to identify the level of care they need. Then, you can more accurately direct the young person to the appropriate service and treatment option.

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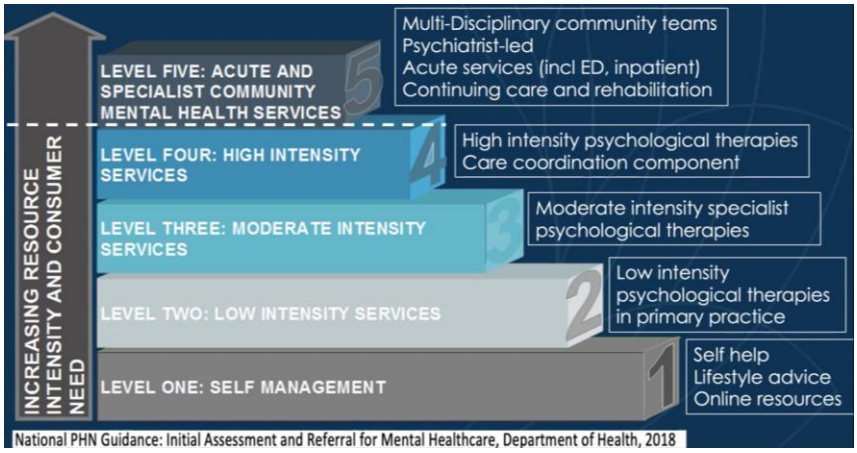

Discuss with your network which services will cover each level of the stratified model and clarify the type of treatments each service can provide. Once an agreement has been reached, it may be useful to create a personalised diagram like above and disseminate across your network, so everyone is aware on their position in the system. When a young person enters the system, it may be helpful to identify the level of care they need. Then, you can more accurately direct the young person to the appropriate service and treatment option

Centralised intake, assessment and referral

Young people's pathway to care is often complex, chaotic and inefficient. Centralised intake, assessment and referral systems can facilitate single points of entry and enable more efficient access to primary, secondary, tertiary services. This can be achieved via:

- Standardised intake and assessment tools such as the Initial Assessment and Referral Decision Support Tool. This can create shared language across services, allowing for rapid cross referral to most appropriate services.
- Warm referrals between services (i.e. specific custom-made pathways to avoid using mainstream intake systems; or create 'fit for purpose' new ones as per need)
- Commitment to providing feedback on referrals received by partners.
- Nominated key contacts in each service to support referrals/build relationships between services.
- Common orientation for new staff/services across system.
- Joint training and planning opportunities and 'community of practice'
- Develop joint consent to share patient information between services. See
- Ensure there are regular clinical discussion forums and meetings between services

- Define and agree on clinical escalation pathways.

Useful links

Initial Assessment and Referral Decision Support Tool – IAR Decision Support Tool

https://iar-dst.online/#/

https://www.health.gov.au/resources/publications/initial-assessment-and-referral-decision-support-tool-iar-decision-support-tool?language=en

Right care, first time, where you live

https://www.rightcarefirsttimewhereyoulive.com.au/sites

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Service Delivery Checklist

Please use this checklist as a guide for possible action items towards improving integration for **Service Delivery**. You can write anything you like in the 'Extra Notes' section.

Item	Completed? (Y/N)	Extra Notes
1. Have we mapped the treatment options available for young people at each level of the model *(Note: The service mapping excel template may be helpful for this)?*		
2. Have we considered which services will cover each level of the stratified model and clarify the type of treatments each service can provide		
3. Are we using standardised intake and assessment tools?		
4. Have we developed warm referrals between services?		
5. Have we developed a way to provide feedback on referrals received by partners?		

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6. Have we nominated key contacts in each service to support referrals/build relationships between services?		
7. Have we developed orientation for new staff/services across systems on centralised process?		
8. Have we established a 'community of practice' around stratified care?		
9. Have we established a joint consent process to share patient information between services?		
10. Have we organised regular clinical discussion forums and meetings between services?		
11. Have we defined and agreed on clinical escalation pathways within and between services?		