The Partners in Recovery program: mental health commissioning using value co-creation

Summary

- The Australian Government's Partners in Recovery (PIR) program established a new form of mental health intervention which required multiple sectors, services and consumers to work in a more collaborative way.
- Brisbane North Primary Health Network applied a value co-creation approach with partners and end users, engaging more than 100 organisations in the development of a funding submission to PIR.
- Engagement platforms were established and continue to provide opportunities for new co-creation experiences.
- Initially, seven provider agencies — later expanded to eight to include an Aboriginal and Torres Strait Islander provider organisation — worked collaboratively as a Consortium Management Committee.
- The co-creation development process has been part of achieving the co-created outcomes, which include new initiatives, changes to existing interventions and referral practices, and an increased understanding and awareness of end users' needs.

The Australian Government's Partners in Recovery (PIR) program[1] established a new form of mental health intervention aimed to better support people with severe and persistent mental illness with complex needs, and their carers and families. It aims to achieve this by getting multiple sectors, services and consumers to work in a more collaborative, coordinated and integrated way.[1] Commissioning these services required an approach that engaged many stakeholders to generate a model that was widely supported and understood. Value co-creation offers a framework to describe this style of commissioning and has been applied to mental health commissioning internationally.[2-6]

Co-creation entails a new vision of value creation through a shift in thinking about the co-creators of value, the value networks, and the entire value of ecosystems.[7,8] It involves redefining the way an organisation engages with individuals, partners and stakeholders by bringing them into a process of value creation and engaging them in enriched experiences throughout the journey, in order to design new products and services, transform management systems, and increase innovation, productivity and returns on investment.[7-11] Co-creation requires focus and sustained efforts in making choices of where and how to co-create value with stakeholders and end users.[9,10] Elsewhere in this Supplement, Janamian and colleagues[12] describe value co-creation approaches and strategies to achieve value co-creation in primary care services research.

The aim of this article is to illustrate how the Brisbane North Primary Health Network (PHN) applied value co-creation approaches to the PIR program to co-design a solution with the partners and end users. Here, we focus on the co-creation processes; formal evaluation outcome data will be provided in detail elsewhere in future reports and publications. Only through the direct engagement and co-creation with stakeholders could the government's program guidelines be translated into a real service that functioned effectively. The PIR program was established in two phases. Phase one is the collaborative work undertaken in the development of the funding submission in 2012–13; and phase two is program delivery from 1 July 2013 to the present.

Mental health commissioning in Brisbane North

Identifying and engaging stakeholders

Stakeholders encompassed not just providers of specialist mental health services, but also primary health care providers, emergency services, social services and consumers of these services and their families/carers.

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Involvement of stakeholders across multiple sectors and organisations produced new capacities and widened the scope and scale of interactions and experiences. This expansion of value creation in a "win more, win more" fashion leads to more transformational results as the scope of application expands — meaning that more and more people gain some impact or benefit from the co-created processes and outcomes.[7-9] Brisbane North PHN (the PHN) engaged more than 100 organisations in the development phase, either by direct invitation or by public advertisement. The service model was developed through a series of three workshops in the last half of 2012. An additional workshop exclusively for consumers of mental health services and their families/carers identified the key outcomes that the model should deliver. A meeting of Aboriginal and Torres Strait Islander agencies was also convened.

During this phase, stakeholders reported satisfaction with the open and participative process, and they strongly embraced the opportunity to feed into development of the model. The outcomes of each workshop were documented and fed back to all participants, in an iterative process that co-created the service model. Champions for the PIR program and the PHN model emerged from these workshops and, through the process, 22 organisations expressed interest in forming a working collaborative. The PHN ultimately selected seven mental health specialist providers, the local hospital network (Metro North Hospital and Health

Service), the Queensland Alliance for Mental Health (the state's peak body for community mental health), and consumer and carer representatives to form the Consortium Management Committee (CMC). While the service model was co-created with all stakeholders' participation, the budget was finalised by the CMC.

Co-creation experiences and platforms of engagement

A range of engagement platforms were established in 2013, each providing stakeholders opportunities for new co-creation experiences and outcomes of value.[7-9] A key premise of co-creation is that by sharing experiences, the individuals involved will gain a greater understanding of what is happening on the other side of every interaction, enabling them to devise a new, better experience for both sides.[10] Agency chief executive officers and senior managers meet with consumer and carer representatives as the CMC every 6 weeks. Service managers within agencies also meet 6-weekly and direct delivery staff meet in learning sets every month. A client information management software platform is used by all agencies, providing staff across eight separate agencies direct access to client information. An analysis tool enables real-time interrogation of both outcome and process data, and program-wide reports. This has facilitated the ongoing co-creation of quality improvements and the potential for integration with clinical data from primary care or public mental health services.

PIR regularly produces short videos, circulated on YouTube and other social media platforms, which update stakeholders on progress and showcase new initiatives. Information is available in a widely distributed electronic quarterly newsletter and through an interactive website (http://www.northbrisbane.pirinitiative.com.au). A separate website has been co-created by public and private health providers as a system navigation tool updated directly by providers (http://www.mymentalhealth.org.au). Additionally, an annual forum brings together the wide and diverse range of stakeholders initially involved in the program's development phase. This provides both accountability for those delivering, and opportunities for prioritisation of new initiatives.

Importance of stakeholder value co-creation

Co-creation expands value creation for stakeholders in various ways: value as enacted through co-creative interactions; value as exemplified experiences; and value as emerging from diverse collaborations across multiple sectors and building on stakeholder's existing capabilities.[7] The PHN had limited expertise in working with people with severe mental illness, and an effective service model could not have been created without the genuine engagement of key stakeholders — community agencies, primary health care providers, public mental health services, consumers and carers. Through equal partnership, mutual relationships and sharing of the decision-making power, value was co-created jointly and reciprocally by all stakeholding individuals. A key value of the program was system improvement and, without contribution from the broad range of players operating in the local system, this goal would not have been achieved. In essence, the co-creation development process was part of achieving the co-created outcome.

During the delivery phase, PIR was managed by the CMC. The PHN adopted principles of collective impact[13] and positioned itself as simply one member agency with the "backbone" responsibility for managing the formal partnerships, performance data and reporting accountabilities. PHN staff focused on creating a CMC environment that was high in trust where the PHN operated as a facilitator rather than a funder.

The high levels of trust and cooperation among members was evidenced in their response to performance data. For example, the data showed 3% of PIR clients in the region were of Aboriginal and Torres Strait Islander background, which was in line with overall population prevalence. However, given the over-representation of Aboriginal and Torres Strait Islander people in the target population, it was clear that PIR was not sufficiently accessible. Following discussion, the CMC agreed that an Aboriginal and Torres Strait Islander provider organisation needed to join the collaborative. The seven provider agencies agreed to give up a portion of their existing contracted funding and pool these resources to enable the PHN to formally partner with the Institute for Urban Indigenous Health, and for this agency to join the CMC. Subsequently, the proportion of Indigenous PIR clients increased. In this way, members of the CMC demonstrated that they were committed to making changes based on performance data, in an environment high in trust.

Co-creation partnership motivations

Dialogue, access, risk—benefits and transparency form the building blocks of value co-creation and require diligent application.[14] The collective management of the program included data sharing and client consent across all agencies. This meant that providers could view client notes from other agencies, and all agencies could access client outcome data. As a result, in addition to the CMC meetings that were attended predominantly by executives, service managers from all agencies met to discuss differences in performance and approach. This has resulted in much stronger connections between agencies at multiple levels, and increased quality of service provision. The delivery system is more self-monitoring, with a convergence of practice, meaning consumers, referrers and other providers have a consistent experience of the program.

Stakeholder value co-creation opportunities

A deeper collaboration with stakeholders across multiple sectors increases the pool of resources, competencies and capabilities, accelerating value creation opportunities for all.[7-9] Agencies collaborated on system improvement activities across a range of projects. Work on the

primary—secondary health care interface was undertaken with public, private and community providers working together to create practical solutions in order to smooth the patient journey across these boundaries. More inter-sectoral work has occurred, and an advisory group including disability services, police and emergency services, and housing and homelessness agencies, was formed to better integrate responses. The CMC oversaw a program to incentivise innovative and collaborative activities, which resulted in work with community pharmacies, education of employers through the Queensland Chamber of Commerce and Industry and the production of new stepped-care models of housing and support. While some of this work has involved new initiatives, much is focused on changing existing interventions and referral practices as understanding and awareness of consumers' needs increased.

Reported benefits of value co-creation

To evaluate the impact of the program, we recruited and trained a team of consumer evaluators who collectively designed the client data collection tool, approached clients directly (and not through their service provider) for interviews, facilitated qualitative workshops, and analysed the data collected.

Although formal results will be reported in future reports, to give a glimpse of the possible impact of the co-creation, early reports include that about 90% of the more than 1500 clients in the program reported experiencing a reduction in unmet need, and about 85% no longer reported problems with connecting to relevant services. Approximately four in ten clients had previously had no contact with the public mental health system and around one in ten PIR clients were of Aboriginal or Torres Strait Islander background. In parallel, our survey of providers found that PIR was thought by some to have contributed to improved coordination between clinical and community mental health providers.

The development of environments which are high in trust also has significant efficiency outcomes. Co-creation and collaborative management means organisations deliver according to their strengths while ensuring program consistency from a consumer perspective. Agencies were also prepared and willing to give up resources to alternative approaches if the evidence demonstrated their value.

Challenges using value co-creation

The value co-creation approach requires a significant commitment of time — not just by PHN staff but also many staff in CMC member agencies, consumers and broader stakeholders. At least initially, it would appear that simply delivering a program independently within an agency is less time-intensive. Formal evaluations are yet to be completed and reported; however, our experiences over 3 years of delivery suggest that investment in strong connections at multiple levels and through many organisations produces better quality for the client and ultimately saves time through a more integrated and collectively planned approach.

The major challenge is giving up long-held models of care that may work for individual agencies but are not effective from a systems perspective. This remains a work in progress, particularly for agencies that are large and complex and for professions that have been delivering care in a particular way for many decades.

Conclusion

The challenges of consistently delivering a program by working through eight separate agencies are considerable. The style and approach of the PHN as backbone to this initiative has a significant impact on the processes and outcomes. The use of value co-creation and collective impact has produced better outcomes for mental health consumers and their families, and has ensured that resources have been applied efficiently to create lasting system improvements.

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