

Developing a Stepped Care System in Mental Health

A discussion document for stakeholder engagement on mental health priorities and the implementation of a stepped care system in South Eastern NSW



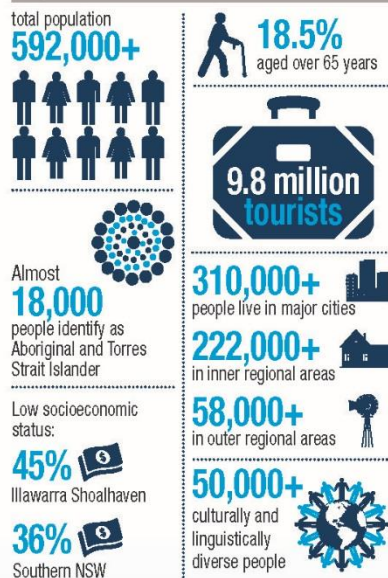
A snapshot of our region



SOUTH EASTERN NSW PHN REGION



Population



Projected population growth:

9.9% by 2021

Primary health care providers



**103 residential aged
care facilities**

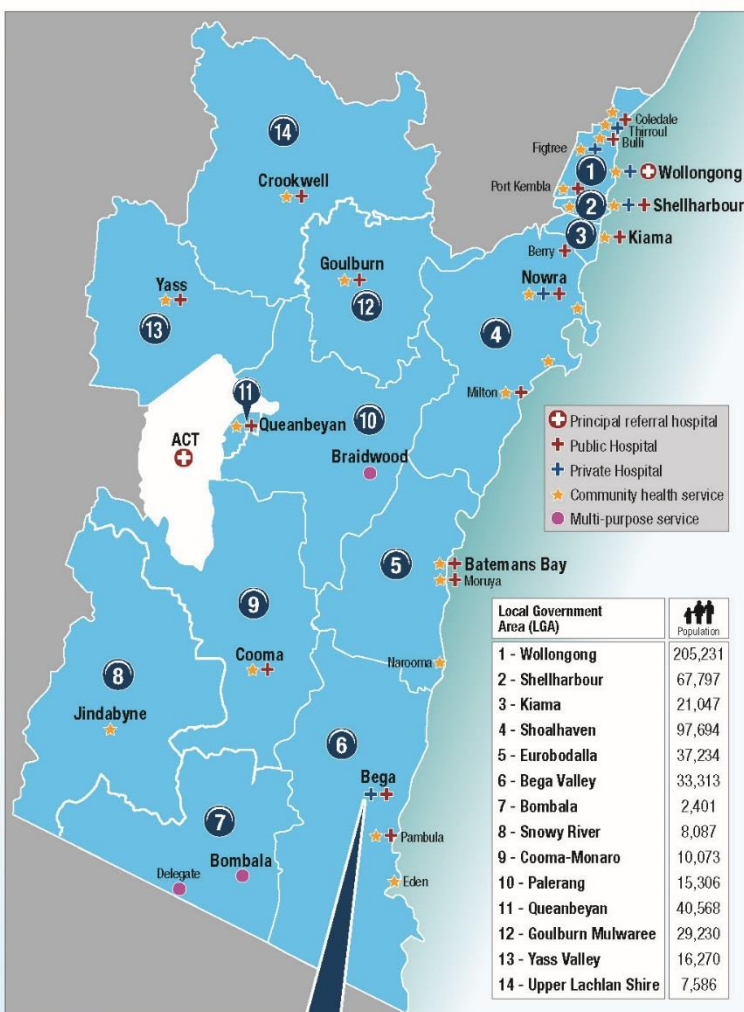
**570 allied health
practices**

System

23 public hospitals
6 private hospitals

Health status - Lifestyle

higher than NSW and Australian
average prevalence figures for
lifestyle risk factors for obesity,
high risk alcohol consumption
and smoking



Future builds

a major health service development – the
construction of the South East Regional
Hospital in Bega – due to open in 2016

Health status - Prevalence



higher than NSW and Australian
average prevalence figures for
chronic diseases including mental
illnesses, arthritis, circulatory system
and respiratory system diseases

Health status - Burden

**Highest burden on local health
services:** COPD and heart failure

**Leading causes of preventable
death:** Cancer (in particular lung cancer)
and circulatory system disorders



Service utilisation



Adults who visited a hospital ED:

10% in Illawarra Shoalhaven

23% in Southern NSW



Cross-border flow: residents from
Southern NSW accounted for
of NSW flows to ACT for
public hospital services

20% of acute service
demand from Southern
NSW residents met by
ACT public hospitals and
met by ACT
10% private hospitals



Data obtained from PHDU 2014, NHPA 2014, NSW Ministry of Health 2014 and Destination NSW 2014

Figure 1: A snapshot of South Eastern NSW Primary Health Network (PHN) region

Introduction

In 2014, the National Mental Health Commission undertook a comprehensive review of mental health services entitled 'Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services'.

The review found that services, programmes and systems were fragmented, that there was duplication in services and they were difficult to navigate. They also found that services were not targeted and there was a lack of localised services:

“The current system is resulting in people not receiving the mental health support they need, when and where they need it, and is offering a poor return on investment in mental health made by all governments and the community more broadly” (Report of the National Review of Mental Health Programmes and Services, National Mental Health Commission, November 2014).

There were a number of recommendations as a result of the review including moving resources “from high cost activity and interventions toward prevention, early intervention, self-care and participation – to enable contributing lives” (Report of the National Review of Mental Health Programmes and Services, National Mental Health Commission, November 2014).

The below diagram portrays clearly the proposed reallocation of resources also allowing for increased treatment rates:

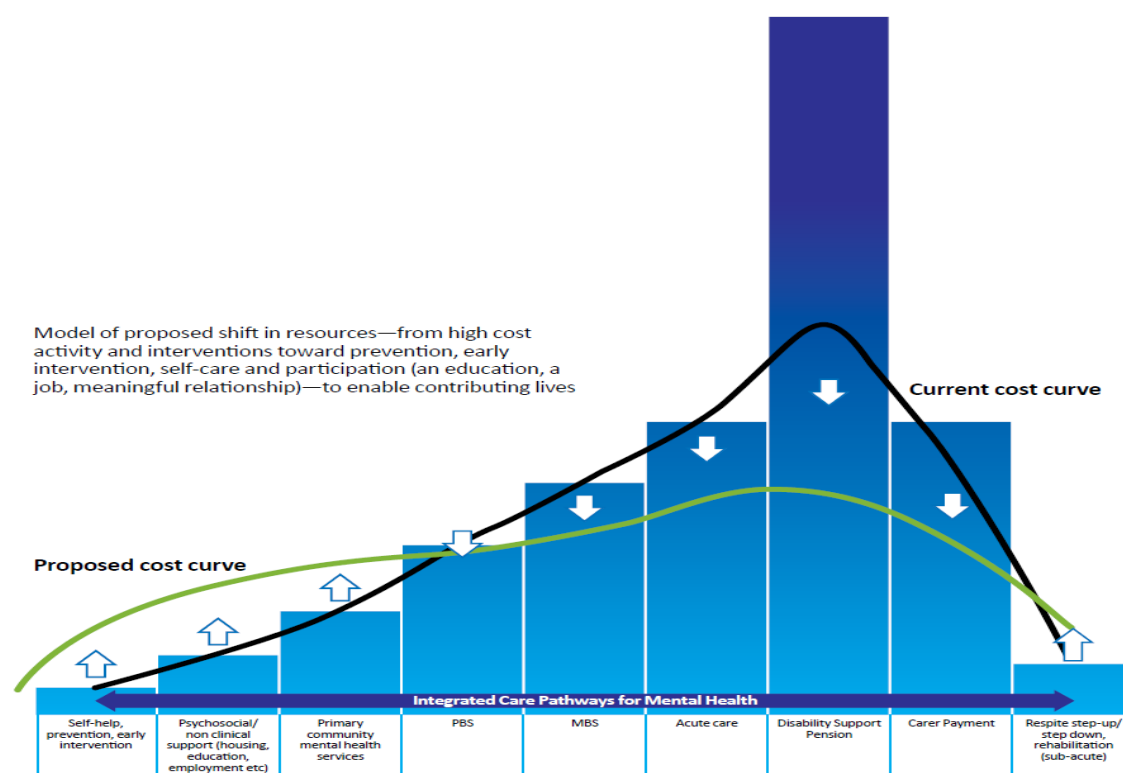


Figure 2: Mental Health Commission review resource reallocation as part of the Report of the National Review of Mental Health Programmes and Services, National Mental Health Commission, November 2014

Another recommendation from this review was to implement a stepped care approach to mental health. This has been actioned via new arrangements with Primary Health Networks (PHNs). Each PHN will design and implement stepped care as a core component of their work in mental health and suicide prevention.

This discussion document provides background on our intended approach to designing and implementing stepped care, including a definition of stepped care and our initial thinking regarding what stepped care could look like for our region.

The aim of this discussion document is to engage with stakeholders in a co-design process, to utilise our collective skills, expertise, knowledge and perspectives to develop a stepped care approach that will improve mental health and suicide prevention outcomes for our population. It is important we co-design our approach to stepped care as it will shape our collective priorities and the services COORDINARE will commission.

This discussion document also outlines the priorities which COORDINARE will be working with, as well as some initial thinking about these priorities, and the process for moving from planning to commissioning services. It shows how the overall PHN vision and priorities are aligned, creating a link from the strategic to the operational.

Timeframes

Implementation of a stepped care approach is not a 'quick fix' solution. It takes time to fully implement a stepped care model. The time expected to implement this approach is expected to be a number of years. This is only the first stage of the process. We will undertake a continuous cyclical approach to the implementation that will involve regular review of the needs of the population, evaluation and review of services, programmes and systems, and determine in collaboration with stakeholders what the next stage of the stepped care should be.

Priorities

Within the design and implementation of the stepped care approach to primary mental health care, COORDINARE will develop strategies for responding to the following six priorities:

- Priority 1 - Low intensity mental health services
- Priority 2 - Youth mental health services
- Priority 3 - Psychological therapies for rural and remote, under-served and /or hard to reach groups
- Priority 4 - Mental health services for people with severe and complex mental illness including care packages
- Priority 5 - Community-based suicide prevention activities
- Priority 6 - Aboriginal and Torres Strait Islander mental health services

Specifically in reference to Priority 5 - Community-based suicide prevention activities and Priority 6 - Aboriginal and Torres Strait Islander Mental Health Services, further information about our approach is provided below:

Priority 5 - Community-based suicide prevention activities

Initially, COORDINARE plans to approach suicide prevention differently in the Northern and Southern parts of our region. This is because there is an established Suicide Prevention Collaborative in the Northern part of the region.

The Illawarra-Shoalhaven Suicide Prevention Collaborative was formed in September 2015 following the expressed commitment from multiple government and non-government agencies to reduce the impact of suicide in the Illawarra Shoalhaven. The Collaborative aims to achieve this by improving the supports available to people at risk of suicide as well as people's experience of these supports; encouraging systems change through collaboration; and ensuring that suicide prevention efforts are effective. As a member of the Collaborative, COORDINARE plans to work closely with the group to ensure that our planning and commissioning aligns.

For the Southern part of our region we plan to look at one focus area in the short term – follow-up care after a suicide attempt. We will determine whether the Collaborative approach in the Northern part of the region is applicable to the Southern region, based on the learnings of the Illawarra Shoalhaven Suicide Prevention Collaborative and considering the needs of the region.

Priority 6 - Aboriginal and Torres Strait Islander mental health services

In undertaking the development of the stepped care approach, COORDINARE acknowledges the Aboriginal and Torres Strait Islander definition of health contained within the National Aboriginal Health Strategy (1989): “‘Aboriginal health’ means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of life view and includes the cyclical concept of life-death-life.”

In line with this definition, the term social and emotional wellbeing (SEWB) will be used interchangeably with mental health throughout the discussion paper which is reflective of a range of flexible, strength-based, holistic and culturally appropriate interventions.

Limited literature exists to evaluate a stepped care approach in relation to Aboriginal and Torres Strait Islander health principles and its application in an Aboriginal health and community setting. This highlights the importance of ongoing consultation and negotiation with Aboriginal and Torres Strait Islander communities and service providers to inform the development of stepped care approach, and the design and development of commissioned services.

Principles underpinning SEWB identified in a range of literature, include:

- health as holistic
- the right to self-determination
- the need for cultural understanding
- the impact of history in trauma and loss
- recognition of human rights
- the impact of racism and stigma
- recognition of the centrality of kinship
- recognition of cultural diversity
- recognition of Aboriginal strengths

(Reference: Working Together – Graham Gee, Pat Dudgeon, Clinton Schultz, Amanda Hart and Kerrie Kelly).

Figure 3 (see over page) depicts SEWB from an Aboriginal and Torres Strait Islander perspective. It is envisaged there is scope to further understand how this may enhance the application of a stepped care approach in an Aboriginal health setting through further consultation with stakeholders and this may look very different to a stepped care approach in a mainstream setting.

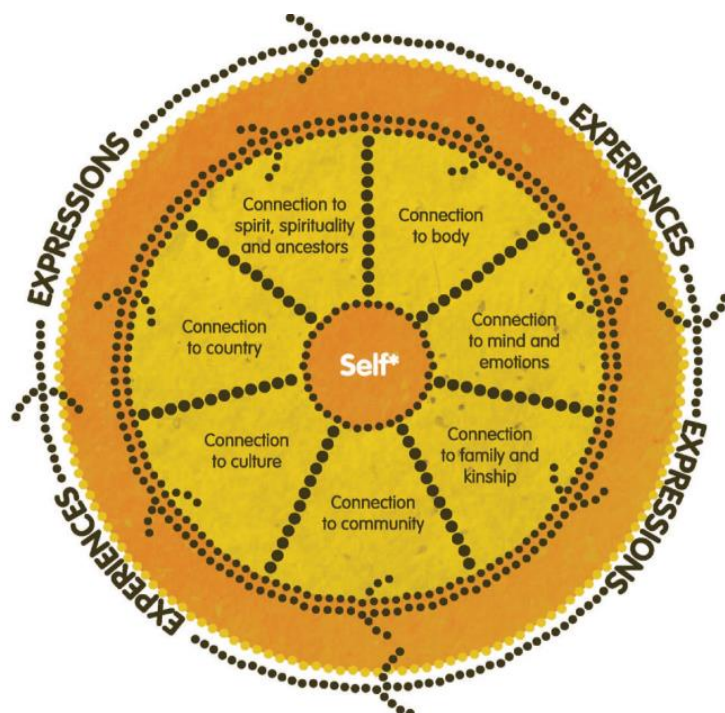


Figure 3: Social and emotional wellbeing from an Aboriginal and Torres Strait Islander perspective

Needs of the population

COORDINARE has recently completed a detailed analysis of the needs across the population in South Eastern New South Wales. Specific analysis of the mental health and suicide prevention needs has also been completed. This analysis has highlighted the following:

- high rates of mental and behavioural disorders and psychological distress amongst adults
- relatively high rates of suicide and self-harm
- high rates of self-harm amongst 15-24 year olds, especially in the Shoalhaven, Bega Valley, Eurobodalla, Cooma Monaro, Goulburn Mulwaree
- high levels of co-existing conditions including physical health and drug and alcohol in people with complex and severe mental health
- high levels of psychological distress and self-harm in Aboriginal and Torres Strait Islander populations
- limited access and barriers to accessing child and adolescent mental health related services and preventative services
- lack of, or poor coordination with, community based mental health services and mental health support services
- inequitable distribution and limited access to psychologists, counsellors, mental health workers and practitioners, consumer workers and consumer peer workers
- gap in service provision for consumers with moderate to severe mental health issues, or people in crisis
- limited access to psychiatry services
- difficulty in navigation, coordination and case management of health and social services for consumers with chronic and complex needs
- limited access to culturally appropriate mental health services for Aboriginal and Torres Strait Islander people
- lack of preventative mental health services
- limited access to drug and alcohol rehabilitation services
- limited access to perinatal and antenatal mental health support services
- lack of or limited access to suicide support services.

This is by no means an exhaustive list; we will continue to build upon and refine the needs assessment of the region as an ongoing function of the PHN. Some examples of the challenges faced in the region include: the vast majority of the population being located in the northern area where there are many services available which may also drive demand; in the Southern part of the region there are challenges around access along with being less resourced, and having more disadvantaged and vulnerable populations.

Copies of the baseline needs assessment and interim mental health and suicide prevention needs assessment are available on request or at www.coordinare.org.au.

The strategic vision of the PHN

As a PHN our vision is to have 'a coordinated regional health system which provides exceptional care, promotes healthy choices and supports resilient communities.'

Our purpose is to support primary care in our region to be:

- comprehensive
- person-centred
- population-orientated
- coordinated across all parts of the health system
- accessible
- safe and high quality

All of our work is guided by the following principles:

- evidence-based
- innovation
- collaboration and participation
- clinical engagement and leadership
- efficiency and value for money
- accountability and transparency

This has resulted in the following mental health and suicide prevention vision statement:

COORDINARE will be a commissioner of high quality, consumer-driven mental health and suicide prevention services. Consumers will experience services that are aligned to a stepped care model, tailored to local needs and offering 'one' coordinated and integrated system of mental health care across the region.

To operationalise this vision the following framework underpins all the work we do (see Figure 4 over page).

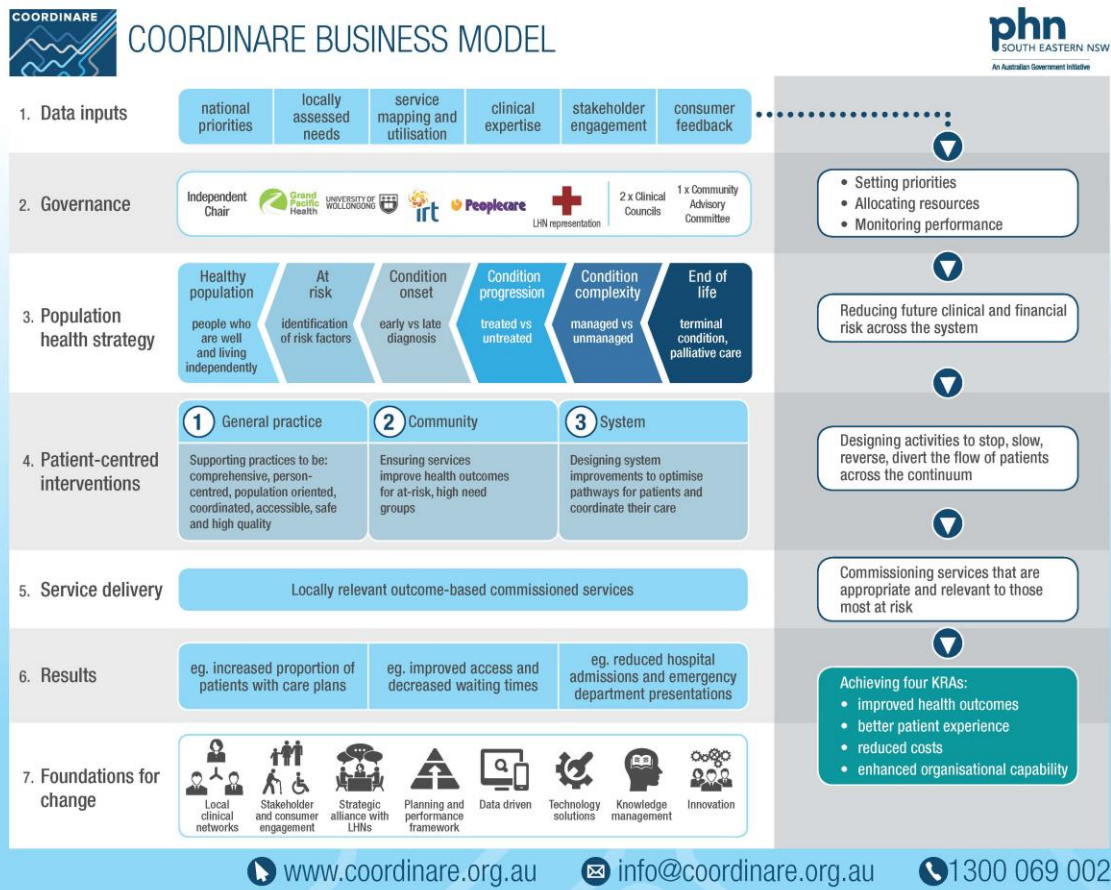


Figure 4: COORDINARE Business Model

Central to this framework is the use of a wellness continuum. This continuum ensures we think about the connectedness and phases of emotional wellbeing that people flow through from healthy with no impact on quality of life to ultra-high complex with significant impact on quality of life. Maintaining wellness and slowing the people flow towards being unwell is an important focus for any health care system. This continuum helps us focus all our work to ensure we are influencing people flows across this continuum to make a real difference.

Applying to mental health

We are using the continuum approach to think strategically about mental health. The diagram below shows our approach to date which we are using to undertake analysis and modelling to understand the numbers of people we can expect across the continuum. This is helping us better understand the needs of the population and also the interventions that we need to design and commission to keep people at the healthy stage with the highest quality of life possible.

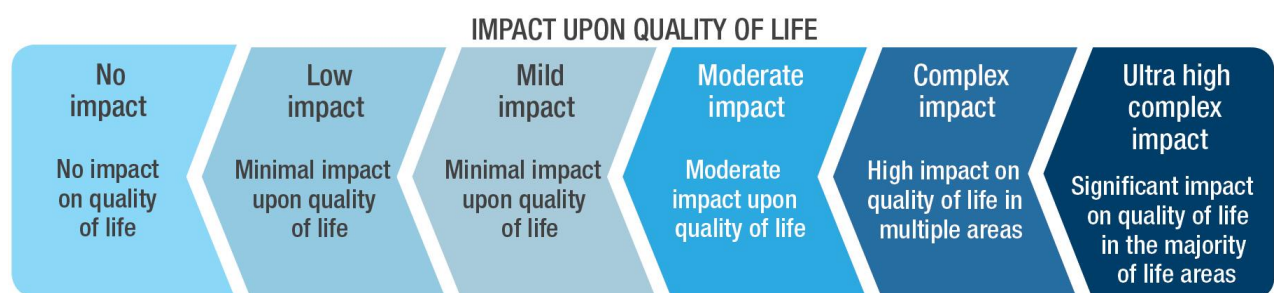


Figure 5: Population continuum applied to mental health

From strategic to operational delivery – linking to stepped care

To meet the needs of our population as shown by the continuum above we will be commissioning services. These services will be commissioned using a stepped care approach. The proposed stepped care approach is described later in this document. The importance of mentioning it here is to illustrate how stepped care is linked to the continuum above ie. creating a link from the overall business model, to mental health and suicide prevention down to stepped care.

Stepped care

Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as directional steps, but rather offer a spectrum of service options.

Any stepped care model must incorporate three key elements:

1. least intensive first: recommended treatment should be the least intensive of those currently available, but still likely to provide significant health gain
2. routine measurement: is self-correcting, results of treatments and decisions are monitored systematically, and changes are made if current treatments are not achieving significant health gain
3. systemic: standardises systems and procedures with the explicit aim of improving effectiveness and efficiency – provides structure and logic to the care system.

In addition to the key elements, any stepped care approach should include the following four core functions:

1. stratification of the population into different 'needs groups', ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions
2. setting interventions for each group – this is necessary because not all needs require formal intervention
3. defining a comprehensive 'menu' of evidence based services required to respond to the spectrum of need
4. matching service types to the treatment targets for each needs group and commissioning/delivering services accordingly.

In a stepped care approach, a person presenting to the mental health system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least intensive level of intervention in order to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their requirements.

COORDINARE's stepped care approach

To support this work we have reviewed the key literature on stepped care and undertaken initial design work. The thinking is that some of the current models in the literature are not ideal for our desired stepped care approach. We believe that some stepped care models are:

- service system centred rather than person-centred
- focus on structures such as 'steps' or 'tiers' or 'ladders' rather than people, families and communities
- do not support the alignment of stepped care within the primary care medical home
- lack clarity about how people access support
- care / support planning is often missing
- some models appear too rigid and don't allow the flexibility necessary to meet needs of specific vulnerable populations.

Key design components

COORDINARE has developed the following key design components to stepped care. We believe the components support a more comprehensive and integrated view of stepped care within the primary care setting and we believe they offer greater flexibility to commission services that will meet the needs of population.

This discussion paper does not aim to describe every element of stepped care in detail, but outline an overall approach to support ongoing engagement and co-design. The key design components include:

Person-centred

- People, families and the community are at the centre of the stepped care approach.
- The approach is based on the principle that all people have the capacity to help themselves and are best supported in the places they live alongside their families and communities.
- The approach keeps people at the centre of all decisions about care and support
- People are linked to general practice wherever possible.

Planning

- Planning is directed by the individual, with support from carers, family, general practice or other services providers only if required.
- Planning as a function is important to all people. This could range from a formal 'care plan' to more informal planning discussions or arrangement. The principle here is that all people benefit from having a 'plan of care' that is theirs, reflects their needs, goals and desires.
- That decisions to 'step up' to a more intensive treatment are based on clinical judgement, clinical outcome measures and consumer preference.

Access

- Our desired stepped care approach supports people having a range of access options or pathways available to them. These could range from self-referral, walk-in, to more formal referral pathways.
- We are also exploring access model options such as a centralised intake process to support improved and consistent access.
- The access function is likely to include access to information, advice as well as screening or triage/assessment activities.
- There is always a pathway available to those with high need.
- Fast track access to specialist mental health services.

Support and interventions

- The approach includes the range of support and intervention options and choices that we believe would be beneficial to include as part of our stepped care approach that are matched to individual needs. These range from lower to higher intensity options including information and advice, eTherapy, self-help, brief therapy (ie. cognitive behaviour therapy (CBT)), single session therapy, youth mental health supports, peer to peer specialist advice and support, specialist mental health services and options for primary care to offer enhanced support.
- Other important elements of the approach are the explicit links to specialist services and the integration of health and social care support. We strongly believe our stepped care approach must integrate across both health and social determinants.
- The least intrusive treatment appropriate to meet the presenting need is offered.
- Some basic 'self-help' advice and support is appropriate for everyone, no matter how complex the difficulties might be.
- Specialist services support primary care with peer to peer support and advice via 'shared care' arrangements.

Integration

- It will be essential in the approach that we see people as a whole, living in a community with basic needs that have to be met such as having a home, but who may require additional service or social supports to promote and support overall wellbeing of the population.
- To support the shift towards more people within the population having no or low impact on quality of life outlined earlier requires alignment with this broader range of services and supports.
- This approach is integrated across health and social care supports as people may require. Supports may include drug and alcohol services, education, employment, social services, housing, or disability services - again tailored to an individual's unique requirements.

Evaluation

- That consumer experience and outcome measures are collected and reviewed regularly.
- That clinical outcome measures are routinely collected at contact points and also reviewed regularly.

Questions to consider:

1. Does the stepped care approach we are presenting make sense?
2. Is there anything missing or do you see any gaps?

Challenges and opportunities of implementing stepped care

Current programs

Historically our primary care mental health and suicide prevention programs have been delivered via a siloed approach. The stepped care approach outlined in this paper aims to integrate these programs into a consistent approach to primary care mental health and suicide prevention delivery. We strongly believe that a move away from program centric approach to a 'person-centred' approach is critical to realising a new model for primary care mental health and suicide prevention. Practically this focus means that over time individual programs will be dissolved or incorporated into the stepped care approach. This will present challenges, but also opportunities for innovation.

Workforce

The stepped care approach is likely to present challenges and opportunities for our workforce. The final design may require workers with different skills and competencies. It is also likely to challenge the distribution of our workforce across the region and whether we have the right workforce in the right places. There are likely to also be opportunities to use the skills of the workforce differently, to enhance new ways of working and potentially drive innovative new workforce models such as peer support.

Start here opportunities

This paper presents a starting point for discussion on stepped care. To fully implement a stepped care approach will take some time. That said there are likely to be some better places to start than others. For example are there opportunities to redesign intake processes, or commission low intensity services or services for those with more complex needs. Alternatively, do we explore implementing a range of changes? It's important wherever we start, that we do so in the context of the overall design of stepped care.

Questions to consider:

3. What challenges do you see with implementing the stepped care approach?
4. What opportunities do you see with implementing the stepped care approach?
5. What are areas for improvement and solutions in the first stage?

How we plan to respond

To respond to the priorities from the Government and the needs of our population, we will be undertaking a co-design process with stakeholders. This involves:

- the development of this discussion document
- a series of stakeholder engagement opportunities (see below)
- alignment with Clinical Councils and the Community Advisory Committee
- establishment of a small working group to progress the development of the stepped care approach

Getting involved

This is only the first stage in developing the stepped care approach. There will be future and ongoing opportunities to be involved.

There are a couple of ways to get involved in this first stage:

1. Respond to questions in this paper via the online survey at:
<https://www.surveymonkey.com/r/MHpaper>
2. Attend one of three stakeholder events:

Narooma Workshop
14 September 2016
9:30am – 4:00pm
Narooma Golf Club
1 Ballingalla St, Narooma

Kiama Workshop
16 September 2016
9:30am – 4:00pm
The Pavilion Kiama (at Kiama Showground)

Queanbeyan Workshop
19 September 2016
Best Western Central Motel & Apartments
11 Antill St, Queanbeyan

RSVP: by Friday 9 September 2016

Registrations can be made by emailing Louise on lroser@coordinare.org.au or by calling 4474 8410.

When registering please note which workshop you are interested in attending, your name, organisation, contact number, email address and if you are a service provider, consumer or carer.

General Practice

We recognise the importance of having general practice involvement and input. In addition to the abovementioned opportunities, we will provide opportunities for input via clinical work groups and focus groups at future Cluster meetings.

Contact us

If you have any questions about this discussion document, please contact Alison Bradley – Mental Health Service Development and Performance Manager (abradley@coordinare.org.au).