phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

# Redesigning primary mental health care in North Western Melbourne

DRAFT

**North Western Melbourne Primary Health Network**

30 January 2017

# Glossary

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|---|---|
| **ACCHO** | Aboriginal Community Controlled Health Organisation |
| **AMHS** | Approved mental health professional |
| **AOD** | Alcohol and other drugs |
| **ATAPS** | Access to Allied Psychological Services |
| **CAMHS** | Child and Adolescent Mental Health Service |
| **CALD** | Culturally and linguistically diverse |
| **CCU** | Community care unit |
| **CYMHS** | Child and Youth Mental Health Service |
| **D2DL** | Day 2 Day Living |
| **FMHSS** | Family Mental Health Support Service |
| **GP** | General Practitioner |
| **LGBTIQ** | Lesbian, gay, bisexual, transsexual, intersex and queer |
| **MH** | Mental health |
| **MHNIS** | Mental Health Nurse Incentive Scheme |
| **MHSOC** | Mental Health System of Care |
| **NGO** | Non-government organisation |
| **NWMPHN** | North Western Melbourne Primary Health Network |
| **PARC** | Prevention and Recovery Care |
| **PHN** | Primary Health Network |
| **PHaMs** | Personal Helpers and Mentors |
| **PiR** | Partners in Recovery |
| **SPS** | Suicide Prevention Service |



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# Contents





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# 1 Introduction

North Western Melbourne Primary Health Network (NWMPHN) is one of 31 Primary Health Networks (PHNs) established on 1 July 2015 to plan and commission primary health services on behalf of the Commonwealth Government. PHNs were established to:

- increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improve coordination of care to ensure patients receive the right care in the right place at the right time.

## Our vision, mission, values and goals

NWMPHN's vision is to improve the health of everyone in our region.

Our mission is to strengthen primary health care and connect services across the system. Equity, respect, collaboration and innovation are the guiding values that we apply to everything we do and every interaction we have.

NWMPHN's goals are:

- Respond to local and national priorities in order to reduce the burden of disease and improve population health outcomes.
- Improve quality of care and individual outcomes.
- Improve integration and coordination of care across the continuum.
- Create a sustainable organisation which is well positioned to influence the reform of the health care system and take advantage of new opportunities.

We do this by:

- identifying and understanding the priority needs in our region
- supporting, developing, innovating, coordinating and measuring service responses to address priorities
- strengthening and supporting general practice and the system as a whole
- demonstrating a commitment to quality, safety, efficiency, genuine value and innovation in everything we do
- working closely and collaboratively with governments (Commonwealth, State and Local); general practice and other primary health care service providers; local hospital networks; non-government organisations; the private sector; and patients, consumers and carers.

## Rationale for developing a mental health system of care

The Commonwealth Government has funded PHNs to plan for, and commission, primary mental health from 1 July 2016, guided by the Commonwealth mental health stepped model of care presented in Appendix A.

NWMPHN recognises that different consumers require different supports at different times, and that these supports change over time. NWMPHN has localised the Commonwealth Government's stepped care approach by developing a mental health system of care for people who live in the north and west of Melbourne. The approach to a local system of care detailed within this document will seek to better coordinate and integrate the provision of mental health services in the region.

The system of care will embed NWMPHN's commissioning activities of: developing insight; planning and delivering; and evaluate and improve, to support consumers and carers to access quality mental health services and to minimise gaps in the existing system.

In this approach, the alcohol and other drugs (AOD) service system is considered distinct from the mental health service system. However, there is recognition that mental health and AOD services cannot operate in isolation, particularly for consumers with co-occurring mental health and AOD conditions. There are clear opportunities for linkages between services, which the system of care can facilitate.

Suicide prevention services, which are universally available, are also included within the system of care as there is a clear interface between the primary mental health system and suicide prevention services.

## Background to the future system of care

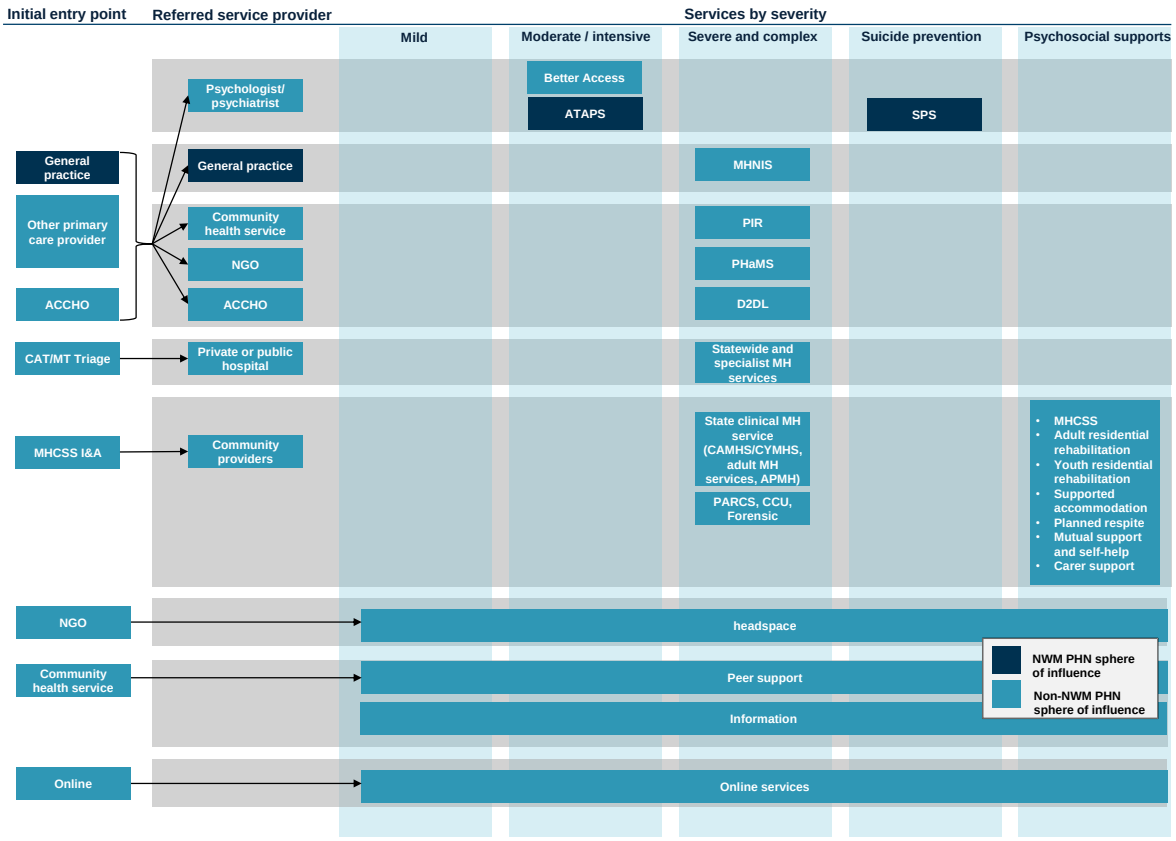
This document makes reference to three mental health models and systems of care:

| | |
|---|---|
| **Historical model of care** | The mental health model of care in place as at 30 June 2016 |
| **Transitional system of care** | The mental health system of care in place for the 2016-17 financial year |
| **Future system of care** | The mental health system of care that will be developed and piloted from 1 July 2017 |

This section will provide a brief overview of the former and transitional models of care, while the rest of the document will outline the future mental health system of care.

### Historical mental health system of care

The figure below outlines the previous mental health system of care, which was in place until 30 June 2016. Activities within NWMPHN's scope of influence were funded directly by the Commonwealth Government, and mostly consisted of primary mental health care. NWMPHN also has ongoing responsibility for the training and education of General Practitioners (GPs), including pathways from GP to primary mental health services, and beyond.



Stakeholders engaged throughout consultation have identified a number of challenges with the historical system of care, including:

→ **Low mental health literacy including understanding of mental health services and pathways** from some primary care providers, particularly for vulnerable groups.

→ **Barriers to accessing a primary care provider** for specific groups of consumers. Barriers can be financial, cultural, linguistic, geographical, or safety and trust-based.

→ **Long wait times** for referral in some areas due to excess demand on the system.

→ **Structural and geographic barriers** impeding referrals to services outside the primary care system in north-western Melbourne.

→ **Gaps in continuity of care** across the spectrum of services.

→ **Limited integration** between services.

→ **Limited understanding** of the roles and skills of other service providers across the sector.

→ **Limited communication flows** between some services, partially due to technological and cultural barriers to information sharing.

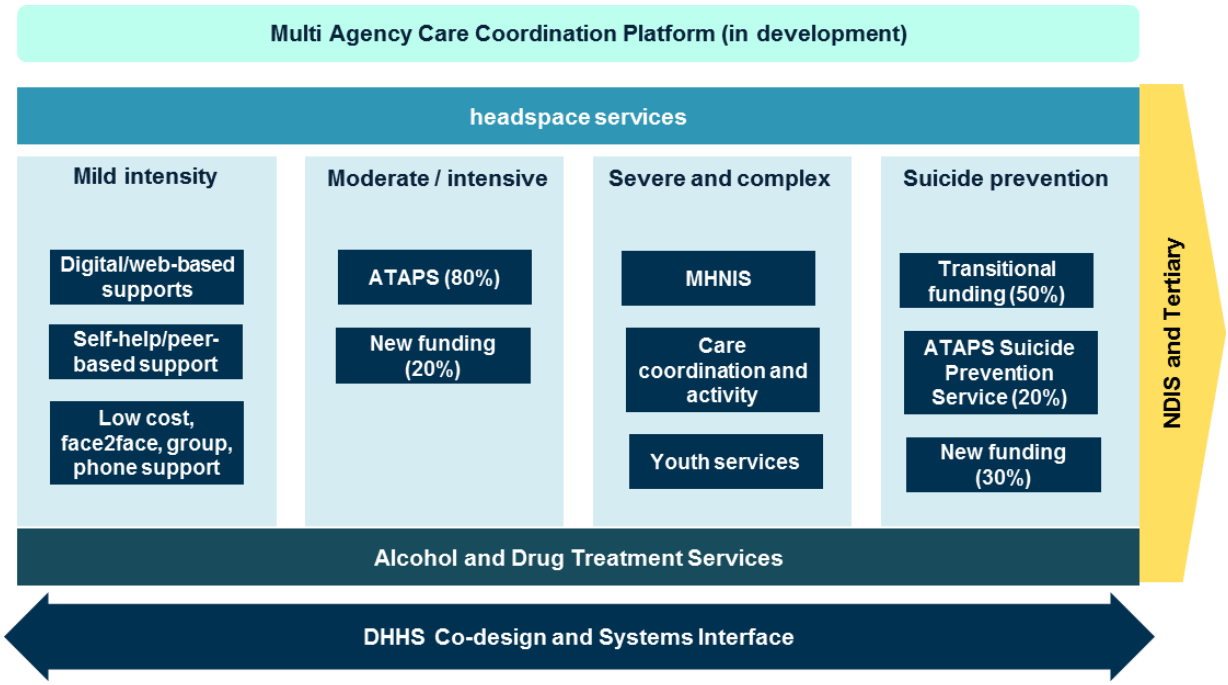
→ **Barriers to accessing services because of stigma** against mental health consumers in the broader system.

These challenges are not unique to the primary mental health care system in our region, but rather are fundamental issues across all streams of activity in State and Commonwealth mental health systems.

## Transitional system of care

To begin to address these challenges, NWMPHN has developed a transitional system of care. This system represents an opportunity to explore innovative ways to address consumers' needs while supporting the service sector by maintaining some continuity with the historical model.

This version of the system of care details commissioning activities for the 2016-17 financial year, in line with the activities committed to by NWMPHN and guidance from the Commonwealth Government. It is also informed by NWMPHN's role as one of ten mental health lead sites across Australia. In this role, NWMPHN will trial innovative approaches to mental health service provision. The diagram below summarises NWMPHN's mental health service activity in 2016-17.



As the year progresses and NWMPHN's engagement and commissioning activities increase, we will develop a deeper insight into how primary care mental health services could be delivered, from both the provider and the consumer perspectives. We will use this knowledge to inform both the future system of care and commissioning cycles.

# 2 Principles underpinning the future system of care

The future system of care is underpinned by a set of principles which are aligned to both NWMPHN's organisational values and the principles contained in the Commonwealth Government's stepped model of care. These principles were developed in consultation with over 200 service providers, policy makes, consumers and carers who engage with services across the breadth of the mental health and AOD sectors.

The principles, as outlined below, will guide the terms of reference for the NWMPHN Mental Health Expert Advisory Group and the NWMPHN Alcohol and Other Drug Expert Advisory Group, and will form the basis for all future mental health and AOD commissioned activity.

| | |
|---|---|
| 1 | **Person-centred:** the system, and the care provided, is person-centred. |
| 2 | **Accessible:** all consumers, including priority populations, have equitable access to services. |
| 3 | **Culturally appropriate:** services are culturally appropriate and safe. |
| 4 | **Integrated:** service providers work to ensure integration across the consumer journey. |
| 5 | **Outcomes-focused:** outcomes are measured at an individual, service and system level. |
| 6 | **High-quality and safe:** consumers have access to evidence based services that are of a consistently high quality across the region and that they feel safe in requesting, accessing and receiving the right service at the right time. |
| 7 | **Innovative:** the system innovates and considers new ways of organising and delivering care, particularly to priority populations. |
| 8 | **Flexible:** services are flexible and respond to the changing needs of individuals, their supports and communities in a timely and consistent manner. |

# 3 System of care

Beyond transitional arrangements, NWMPHN is responsible for developing a future primary mental health system for the north-western Melbourne region that works to support consumers and carers, addresses gaps in the current system and provides innovative solutions to enduring challenges.

## Mental health system of care

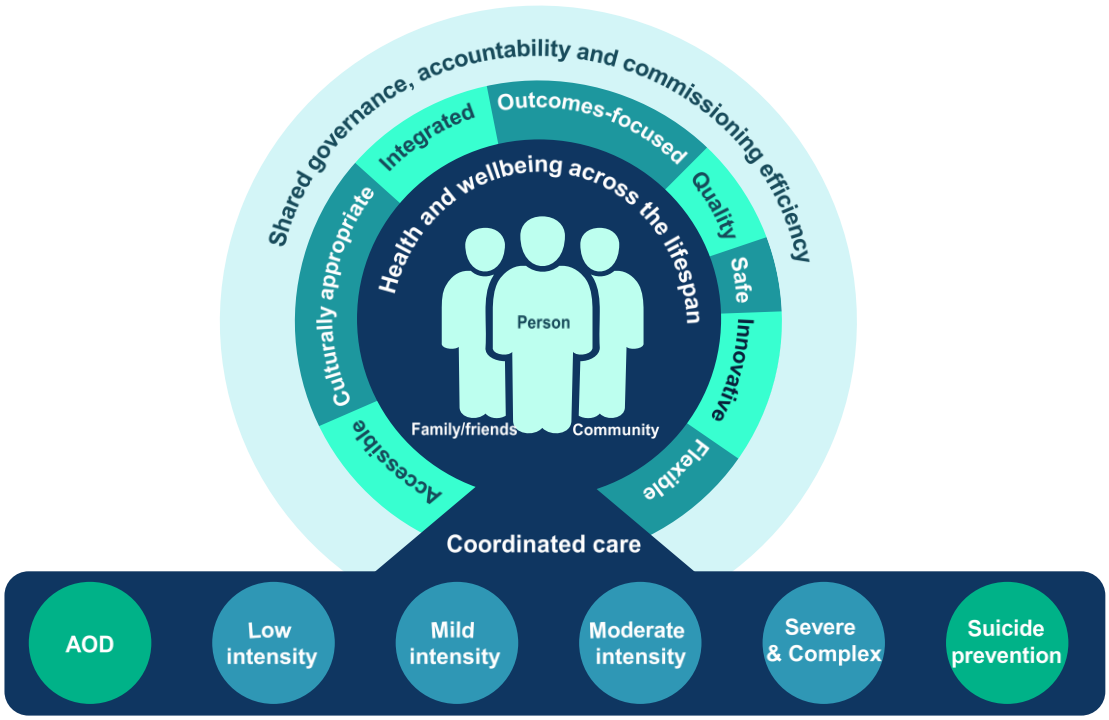
NWMPHN's system of care is a values-based model that includes accountabilities.

The NWMPHN mental health system of care (MHSOC) incorporates key concepts that will guide how NWMPHN will work with consumers, carers and service providers in the commissioning and delivery of primary mental health services.

The model encourages service providers to first look at the person presenting and then respond with a co-ordinated, integrated approach. It details the relationship between the person, their community, the services, a set of agreed principles, shared responsibility and a governance framework.

Co-design and consumer involvement will be a core element of the services that NWMPHN commissions into the future. Coordinated care and the range of interventions on offer will be defined to provide certainty regarding what consumers can expect. The level of service provided to each person will be determined by their needs, a mental health assessment and input from the person, their family and friends as well as involved health care providers.

The model also identifies a number of responsibilities – governance, accountability and commissioning efficiency – that are critical in ensuring the model of care is effective and accountable. The model recognises that the parties involved in delivering care to a person will need to share accountability for the person's health and wellbeing outcomes, regardless of who those parties are.



The key components of the system of care are as follows:

1. The individual is at the centre of the system of care. Services are provided flexibly in a way that meets the needs of the individual, rather than individuals having to fit into pre-existing services.
2. Individuals' health and wellbeing needs are addressed holistically, with mental health and AOD services embedded in a broader health and social system response to the needs of the individual.
3. Services wrap around the individual as well as the individual's family, friends and community, who are recognised as critical supports.
4. The core principles of the system of care are embedded in all services.
5. Care is co-ordinated, and services operate in an integrated way.
6. Individuals are able to access a flexible mix of evidence based services, with the intensity of services varying according to need. Individuals are able to adapt the mix or intensity of services at any time as their needs change.
7. Individuals are able to access AOD and suicide prevention services as needed; these services do not sit on a spectrum of need.
8. The model is supported by shared accountabilities, governance structures, commissioning approaches and ways of working to support the needs of individuals.

### Priority populations

While the MHSOC is for all service providers and consumers, PHN-commissioned services will have a focus on identified priority populations who have traditionally experienced additional barriers to accessing services. Priority populations include Aboriginal and Torres Strait Islander people, people identifying as LGBTIQ, people from culturally and linguistically diverse backgrounds, people who are homeless, refugees and asylum seekers, people transitioning out of the justice/corrections system and people from a low socio-economic background.

NWMPHN will be working in partnership with our local Aboriginal Controlled Community Health Organisation (ACCHO) to co-design mental health, suicide prevention and AOD treatment services in order to achieve the best health and wellbeing outcomes for Aboriginal and Torres Strait Islander people.

The work NWMPHN undertook in its catchment-based Initial Needs Assessment identified principles that will be responded to through the system of care and the commissioning process. Without direct action, individuals with need may experience additional barriers when seeking access to services in their region. The need identified includes higher rates of AOD misuse, people with personality disorders and young people with eating disorders as well as areas of socio-economic disadvantage. For more information about the Initial Needs Assessment, please refer to NWMPHN's Regional Health Needs Assessment.

## How the model has been informed

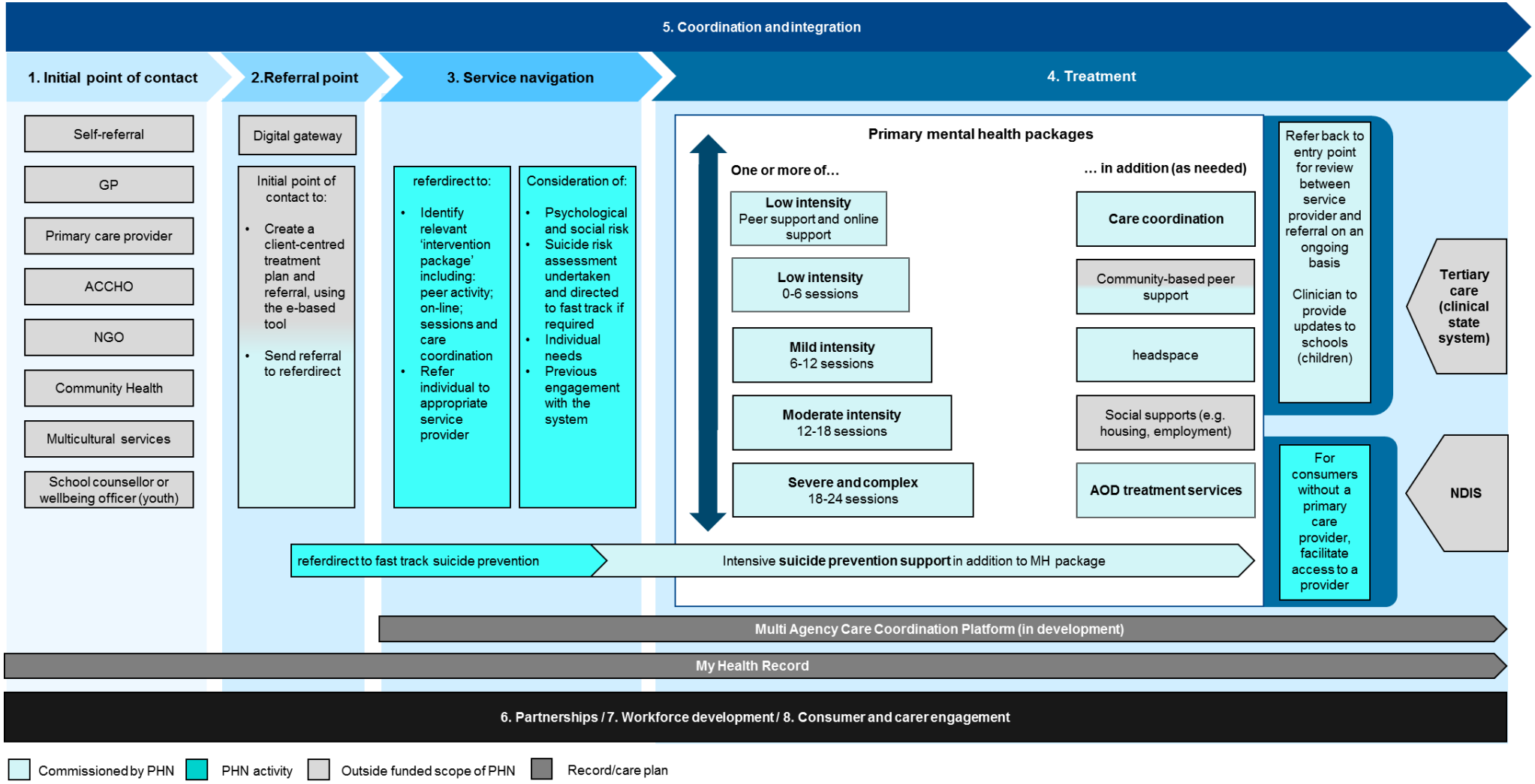
Key consultation activities for the system of care have included:

- on-line survey completed by 161 consumers, carers and service providers
- stakeholder forums with approximately 70 participants representing mental health service providers, AOD service providers, consumers and carers
- input from ongoing stakeholder consultation
- a literature review on primary mental health care models conducted by University of Queensland and the University of Melbourne.

In total, over 250 individuals have contributed to the NWMPHN system of care.

# 4 System structures

The system of care is supported by a revised system structure. This system structure is outlined below with more detail provided in the following section.



The eight core elements of the MHSOC are:

1. Initial point of contact.
2. Referral point.
3. Service navigation.
4. Treatment.
5. Coordination and integration.
6. Partnerships.
7. Workforce development.
8. Consumer and carer engagement.

The following sections provide additional detail on each element of the system of care.

## 1. Initial point of contact

The system that sits behind the MHSOC will support an open approach to accessing services. We will accept referrals for people from priority populations, and work with the referrer to ensure the appropriate service is received at the right time. Clear and consistent health pathways and health literacy resources will support providers and clients to understand and navigate the new system.

The majority of people will be encouraged to visit a general practitioner or other primary care provider (including school wellbeing officers or counsellors for children and young people) as an initial point of contact in seeking mental health support.

In recognition that priority populations commonly experience barriers to accessing primary care providers they will be able to seek help by accessing their local services. People will also be able to self-refer to low intensity services.

## 2. Referral point

The primary care provider or service provider serving as the referrer would conduct an initial assessment and prepare a person-centred mental health treatment plan, and then forward this navigation service via referdirect™. referdirect™ is NWMPHN's on-line client management system which manages referrals for people using NWMPHN funded mental health services and allocates the clinical response.

NWMPHN will have an online training resource available to explain the key practical steps that the provider needs to complete to support the assessment of individuals being referred for mental health service support.

Where the individual providing the initial point of contact does not have the expertise or capacity to conduct an assessment (for example, a non-health universal service), people should be supported by services to engage with an appropriate primary care service or practitioner.

In instances where a person is assessed to be in critical need of suicide prevention services, an urgent referral to an appropriate clinician would be facilitated. This may involve coordinating service provision with the state clinical system. A suicide response will take place within 72 hours.

## 3. Service navigation

Completed referrals and assessments will be sent to referdirect, where clinicians will review intake materials and match the person to a primary mental health care provider. NWMPHN has developed processes to ensure consistency in how assessments are received, reviewed and prioritised to ensure the appropriate primary mental health packages are then provided to those who most need the support.

This process ensures that each person is assessed on a needs basis, and are matched both to an appropriate primary mental health care provider and allocated the required support package. Importantly, this will not be a process that is conducted once and then set indefinitely; NWMPHN, the person, and related providers will establish a series of regular and 'as required' review mechanisms to identify when services could be

completed, or when there may be a change in a person's circumstances or issues that require a revision of the supports needed.

NWMPHN's processes to match people with the most appropriate services will be underpinned by the principle of prioritising access for those who experience greater barriers in accessing services, in line with Commonwealth directions. Specifically, the groups that will be prioritised are: underserviced groups, people with severe and complex needs, people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples, and children and young people.

## 4. Treatment

The MHSOC recognises that people rarely move through system in a linear way. As treatment progresses a person may require additional or less support, and potentially require different combinations or packages of care to best suit their needs as they move towards recovery. The system of care also highlights the need for co-ordination in more complex situations between multiple providers involved with an individual.

Once a person has completed a psychological or suicide prevention assessment and are referred for treatment, they will be eligible to access a set number of tailored services according to their needs and goals. Available services will include online interventions, peer support, counselling, care coordination, case management and AOD-specific treatment services as required. The number of sessions that a person will be able to access would depend on the outcome of their mental health assessment as proposed below:

- **Low intensity:** involving community based peer support as well as services that do not require a referral (e.g. online self-help tools); number to vary depending on approach and need.
- **Low intensity:** up to six sessions.
- **Mild intensity:** up to 12 sessions (assessed after six sessions if required).
- **Moderate intensity:** up to 18 sessions (assessed after nine sessions).
- **Severe and complex:** up to 24 sessions (assessed after 12 sessions).

A service 'session' is defined as a time-limited (generally one hour or increments of) clinical intervention provided in response to the assessed complexity and functional needs of a person with a suitably qualified practitioner. Sessions will vary in nature according to the setting, need and required interventions.

In addition to session-based interventions an person may also be provided a broader suite of services, if needed, particularly if they have more complex care needs. The following services may be provided to a person assessed as requiring other supports:

- **Alcohol and drug treatment:** tailored alcohol and other drug treatment sessions.
- **Care co-ordination:** involving regular support with a consistent service provider who links consumers with the appropriate providers and service supports.
- **Community base peer support**: enabling local non-primary care support for a broader suite of social needs through recognised peer networks.
- **Social supports**: linking people to local services, based on need such as housing, family services, employment; NB services not funded by NWMPHN but linkage provided
- **headspace services**: linking young people (aged 15-25) to youth-specific services.

### Review

A person receiving services will be encouraged to return to their primary care provider at regular intervals for review of their level of functioning and/or need and goal achievement. Where a person does not have an identified primary care provider, they will be actively supported to access and link with appropriate providers for review by service providers or care coordinators.

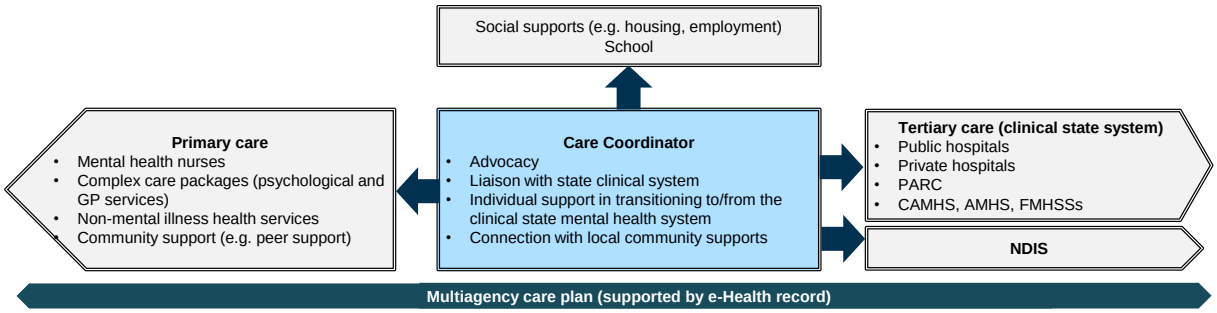
People will be encouraged to connect with local community-based peer support networks and/or the local service that originally referred them, where these services may have additional non-primary care supports available.

### Suicide response

In addition to primary mental health packages, people identified to be in need of suicide prevention treatment will be able to access additional intensive supports. For a person assessed as requiring suicide prevention support, access to these services will be fast tracked. While these services will facilitate expedited access for this group, it is important to note that it will not replace an emergency response or the more intense crisis assessment response provided by state-based community mental health services where there may be more immediate suicide risk. Liaison and communication between providers in these cases will be a focus under the new system of care.

## 5. Coordination and integration

To respond to the identified gap of coordination between services for a person with severe and complex mental illness who are not acutely ill and do not require clinical care (or may be transitioning from clinical care), the model includes the establishment of the Care Coordinator. As outlined below, the Care Coordinator would play a key role in coordinating and facilitating care for a person, advocating for their needs and acting as a liaison between primary care providers and tertiary care.




Critically, Care Coordinators will also play a role in providing support to people transitioning out of the state mental health system. In doing so, Care Coordinators aim to prevent re-hospitalisation by connecting a person to primary care providers and community supports (e.g. peer support workers).

Within this model of care, the role of care coordinators will be articulated to ensure that across all treatment streams clients have access to evidence based care coordination principles and supports.

## 6. Partnerships

NWMPHN is establishing partnerships with service providers who work with (or may work with in future) at-risk and priority populations. Developing and fostering partnerships with the sector is a critical element of NWMPHN's commissioning approach.

In particular, NWMPHN will co-design service delivery with primary and tertiary care providers focusing on particular groups of at-risk clients who may have limited support in the current system for example, people with enduring mental illnesses.

Under the system of care, NWMPHN has started to identify key areas of focus and initial development of practical partnerships with stakeholders in these areas.

## 7. Workforce development

Workforce development is an essential component in the development and roll out of the MHSOC. The workforce development program will support all participating contracted providers to build their skills and knowledge (where provided) to practice to high clinical standard.

The workforce development program will also include the establishment of a community of care. The community of care will be a peer based network that ensures practice is evidence based and learnings shared.

NWMPHN will provide:

- Practice tools and evidence-based referral guides to ensure that primary care providers refer people to the right care at the right time
- Best practice regional service provider information, linked to the HealthPathways system. HealthPathways Melbourne is a free, web-based portal with relevant and evidence-based information on the assessment and management of common clinical conditions including referral guidance:

  melbourne.healthpathways.org.au
- Support to providers to develop and maintain culturally appropriate and safe services that holistically meet the needs of people and their families
- Support to build the capacity of primary care services to support people at risk of suicide.

## 8. Consumer, carer and stakeholder engagement

NWMPHN has actively engaged clients, carers, advocacy groups and key stakeholders through the development of the MHSOC, and will continue to do so as core activity. These relationships are critical to ensure NWMPHN's understanding of what is happening on the ground, within the catchment. The program of engagement includes both formal and informal activity and seeks both qualitative and quantitative data/information.

Formally, NWMPHN is establishing an independent Mental Health Expert Advisory Group with the purpose of advising, informing and supporting the mental health program of activity. In addition, there will be an annual consultation program to discuss progress on mental health service delivery, and there will be an open call for feedback on the NWMPHN website for any person, professional or organisation to identify an issue and inform NWMPHN.

Informally, NWMPHN and its staff will continue to actively participate on key groups, committees, networks and consultations.

# 5 Our approach to commissioning

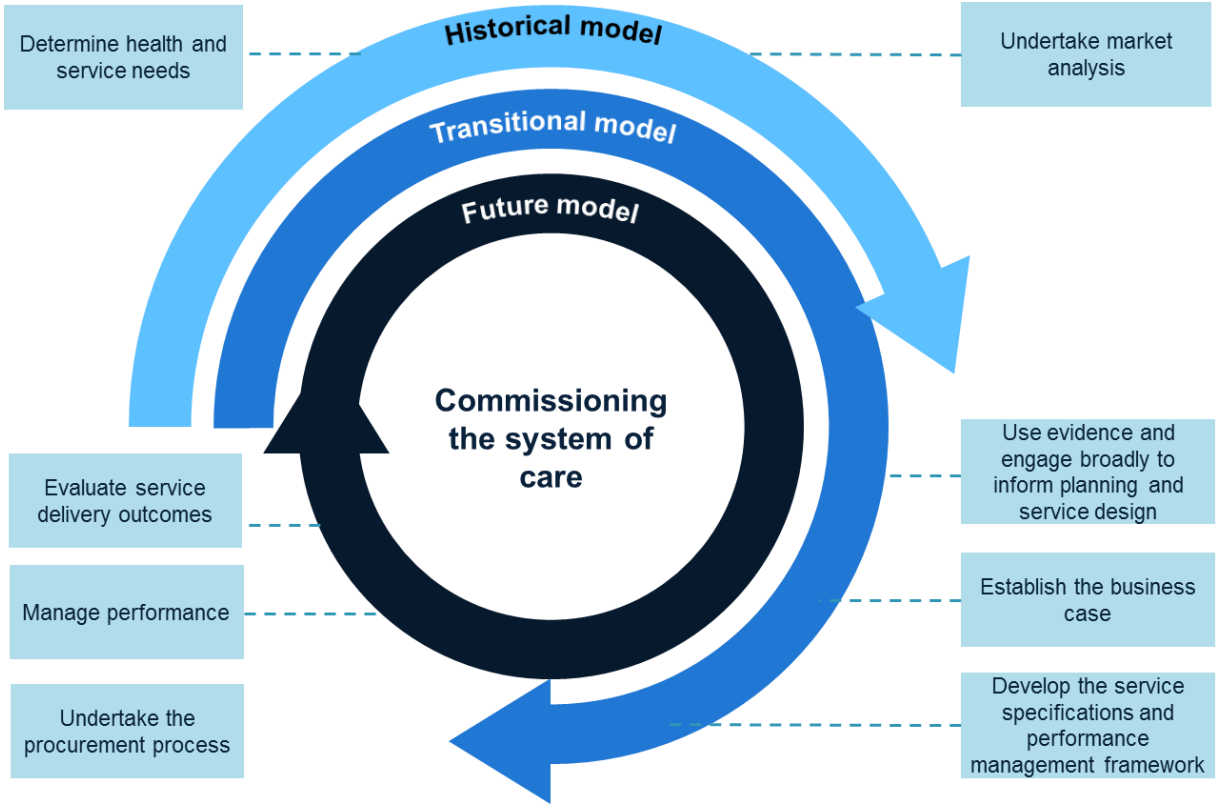
The system of care has been developed with ongoing stakeholder consultation, a component of NWMPHN's commissioning cycle. NWMPHN's core activities in supporting the system of care are:

- Preparing and updating mental health needs assessments to better understand the need for mental health, AOD and suicide prevention services in the community.
- Facilitating ongoing consultation and co-design with stakeholders across the sector, including clients and carers, to ensure that the model is informed by the needs of its users.
- Developing the relevant workforce by supporting ongoing training and commissioning mental health service providers.
- Coordinating service delivery by commissioning services in a way that encourages service integration.
- Monitoring the delivery of commissioned services and measuring the effectiveness of services.

As outlined in Section 1, NWMPHN has undertaken these activities using a staged approach:

- Under the historical model, NWMPHN prepared the Initial Needs Assessment for the Commonwealth in March 2016 and commenced ongoing stakeholder consultation.
- In the transitional model, NWMPHN is focused on service planning and developing its commissioning approach, as it begins to pilot new approaches.
- In the future model, NWMPHN will have an established process for procurement, managing performance and evaluating performance. Planning, consultation and commissioning activities are ongoing in the future model.

NWMPHN's commissioning cycle is summarised below.



# 6 Quality, accountability and reporting

## Clinical governance

The future system of care will align with the overarching NWMPHN Clinical Governance Framework. Currently the NWMPHN clinical governance approach is underpinned by four pillars, consistent with national and state health approaches. Specifically, these are:

- **Consumer value** – NWMPHN will promote active participation of service users in planning, implementing, monitoring and evaluating the MHSOC to best meet the needs of its community.
- **Clinical effectiveness** – the MHSOC will be underpinned by clear clinical standards, measured through robust clinical indicators aligned to the National Minimum Data Set (MDS) and be supported through a proactive clinical audit strategy.
- **Risk management** – covering the identification and reduction of potential risks and examination of adverse incidents for causal and contributing factors and trends.
- **Effective workforce** – ensuring appropriately skilled, qualified and experienced practitioners are providing services to PHN consumers.

NWMPHN is responsible for driving the focus on providing quality services and the achievement of meaningful outcomes for people using NWMPHN funded services. One of the main clinical governance structures supporting the MHSOC will be the NWMPHN Mental Health Expert Advisory Group and the NWMPHN AOD Expert Advisory Group. Quality assurance mechanisms the group will aim to:

- Support NWMPHN to create greater accountability for outcomes – reinforcing not only the collection of service or output but also a focus on measuring meaningful outcomes for users of the service.
- drive the delivery of safe, quality, evidence based care.
- monitor, review and provide advice on NWMPHN's body of work in Mental Health and Alcohol and Drug activity.

## Outcomes measures – building on the National Minimum Dataset

In order to measure the effectiveness of the model of care at a system level, NWMPHN will develop an outcomes framework in line with the Commonwealth requirements and the MDS. The outcomes will align with the MHSOC principles (in section 2) and be built on the areas of focus identified below.

| Outcomes | Individual | Service level | System-level |
|---|---|---|---|
| **Person-centred** | People are able to access care that is tailored to their needs | Service providers deliver care that is tailored to the needs of the person, rather than expecting people to fit in to existing services | Services wrap around the person |
| **Accessible** | Individuals are able to access the care they need in a timely and affordable manner | Service providers understand and work to address barriers that people face in accessing services | People using the service report being able to access high quality, safe services |
| **Culturally appropriate** | Individuals are able to access culturally appropriate services | Services provided are culturally appropriate and culturally safe | Aboriginal and Torres Strait Islander and CALD community representatives report that services across the system are culturally appropriate |

| | | | |
|---|---|---|---|
| **Integrated** | Individuals do not experience gaps between mental health and AOD services | Services coordinate with other service providers to provide integrated care for clients | Service provision is integrated across the sector |
| **Outcomes-focused** | Individuals are supported to achieve their personal goals and plans | Services identify performance and client outcomes and measure performance against outcomes | System- and- population-level performance outcomes are regularly measured |
| **High-quality and safe** | Individuals are able to access the same high-quality, safe care in any location in the region | Services are high-quality and provide safe care across all locations | The system produces high-quality outcomes and safety principles are embedded across the system |
| **Innovative** | Individuals are involved in co-designing innovative solutions | Services clearly identify challenges faced by clients and propose innovative solutions | The system promotes and incentivises innovative practices |
| **Flexible** | Individuals are able to tailor their care as their needs change | Services are flexible to meet the needs of individual person | The system is able to flexibly scale up, scale down, commission or de-commission services as required |

As with the co-design of service delivery, people will participate in the development and measurement of quality and accountability requirements, through direct representation on the NWMPHN Expert Advisory Groups. Specific client feedback and input on the services delivered will also be captured on a regular basis as part of the ongoing quality assurance process for NWMPHN.

As the system of care develops, all mental health and alcohol and drug funded services will be required to report on the above outcome measures as well as the minimum data set.

Ultimately NWMPHN aims to ensure that all vulnerable individuals and their supports have access to safe, quality, evidence based services that support their needs as and when required.

## Reporting

NWMPHN has a responsibility to both report regularly and listen to all its stakeholders – the Commonwealth, the mental health service sector, the alcohol and other drugs service sector, service providers, people who use NWMPHN funded services, their cares and the community.

Annually, NWMPHN is required to undertake a localised needs assessment and publish this document on our website. This needs assessment, with specific sections on both mental health and alcohol and drugs, forms the rationale of the Mental Health Activity Work plan and the Alcohol and Other Drugs Activity Work Plan, submitted to the Commonwealth. Both plans are accessible on the NWMPHN website.

In addition to the formal reporting, NWMPHN is developing a consultation program, to ensure that all interested people and organisations have regular opportunities to learn about the latest developments in NWMPHN's mental health and alcohol and other drug activity, and provide feedback on both existing as well as planned activity. To find out more about the consultation program please visit nwmphn.org.au

# 7 Your feedback

NWMPHN openly invites comments on this draft document *Redesigning primary mental health care in north western Melbourne.* Please email your comments via mhdasr@nwmphn.org.au or phone us on 03 9347 1188 if you don't have access to email.

NWMPHN is receiving feedback on this draft document up till Tuesday 14 March 2017.

# Appendix A: Commonwealth stepped model of care

| Well population | At risk groups (early symptoms, previous illness) | Mild mental illness | Moderate mental illness | Severe mental illness |
|---|---|---|---|---|
| **What do we need to achieve?** | | | | |
| Focus on promotion and prevention by providing access to information, advice and self-help resources | Increase early intervention through access to lower cost, evidence-based alternatives to face-to-face psychological therapy services | Provide and promote access to lower cost, lower intensity services | Increase service access rates maximising the number of people receiving evidence-based intervention | Improve access to adequate level of primary mental health care intervention to maximise recovery and prevent escalation<br><br>Provide wraparound coordinated care for people with complex needs |
| **What services are relevant?**<br>(Service level matched to individual clinical needs and suitability) | | | | |
| Mainly publically available information and self-help resources | Mainly self-help resources, including digital mental health | Mix of resources including digital mental health services and low intensity face-to-face services<br><br>Psychological services for those who require them | Mainly face-to-face primary care services, backed up by psychiatrists or links to broader social supports<br><br>Clinician-assisted digital mental health services and other low intensive services for a minority | Face-to-face clinical care using a combination of GP care, psychiatrists, mental health nurses, psychologists and allied health<br><br>Coordinated, multiagency services for those with severe and complex mental illness |
| **What do we need to achieve?** | | | | |
| No workforce required | Low intensity workforce with appropriate skills, training and qualifications to deliver evidence-based mental health services, but not at the level required for recognition as a mental health professional, e.g.<br>• Certificate III or IV equivalent recommended entry point<br>• Completion of recognised training in delivery of cognitive behaviour therapy<br>Peer workforce to supplement higher intensity workforce, as appropriate | Low intensity workforce as well as some services by GPs, psychologists and other appropriately trained and qualified allied health professional<br><br>Peer workforce to supplement higher intensity workforce, as appropriate | Central role of GPs with contribution of psychological therapy provided by psychologists and other allied health professionals<br><br>Private psychiatrists and paediatricians involved for some, particularly for assessment and review of clinical needs<br><br>Peer workforce to complement clinical services provided by other workforce | Central role of private psychiatrists, paediatricians and GPs<br><br>Psychological therapy provided by psychologists and other allied health professionals<br><br>Mental health nurses involved in coordinating clinical care and supporting the role of GPs and private psychiatrists<br><br>Peer workforce to complement clinical services provided by other workforce |

**What system changes are needed?**

- **Promote and support availability of self-help and digital mental health services as an alternative and/or adjunct to face-to-face services**
- **Increase capacity over time of clinician-assisted digital mental health services**
- **PHN use of flexible funding to commission range of services to fill gaps**
- **Expand primary care system capacity to better meet needs of people with complex and chronic mental health conditions, including enhanced nursing support and coordinated care**
- **Program redesign and optimal targeting**
- **Integration between service levels**

Source: Department of Health, PHN Primary Mental Health Flexible Funding Pool Implementation Guidance: Stepped Model of Care (2016)