Gippsland PHN

Primary Mental Health and Suicide Prevention Stepped Care

PROGRAM GUIDELINES

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1. Purpose of the Operational Guidelines

The purpose of the Operational Guidelines is to provide operational advice, expectations and guidance and should be read with reference to the Service Order for the delivery of the Gippsland PHN Primary Mental Health and Suicide Prevention Stepped Care Program and the Gippsland PHN Commissioned Services Program Guidelines.

The Guidelines are not intended to be the only source of guidance for clinicians, nor should they take precedence over state or federal policy, which is subject to change. The Guidelines should be followed subject to the clinician's judgement in each individual case.

2. Program summary

Gippsland PHN Primary Mental Health and Suicide Prevention Stepped Care Program is funded by incentives and grants through the Australian Government Department of Health (DoH).

The aim of the Primary Mental Health and Suicide Prevention Stepped Care Program is to provide access to primary mental health and suicide prevention programs within a stepped care model to improve the overall health and wellbeing of people living in Gippsland. Gippsland PHN has the flexibility to commission evidence-based treatment services to meet local need, catchment priorities and service gaps.

3. Aims and Objectives

The Program is commissioned within the overarching parameters of the *Primary Health Network Grant Programme Guidelines* and will contribute to the key program objectives of:

- Increase the efficiency and effectiveness of primary mental health and suicide prevention services for people with or at risk of mental illness and/or suicide; and
- Improve access to and integration of primary mental health care and suicide prevention services to ensure people with mental illness receive the right care in the right place at the right time
- The intent of the Program is to complement existing Commonwealth and state/territory services and improve regional coordination, sector efficiency and duplication of existing initiatives.

4. Program scope

The Australian Department of Health have documented the types of interventions and workforce requirements relevant for each step – see below. This table is not meant to be prescriptive rather it is to provide information and guidance on the stepped care approach.[1]

[1] Australian Government Department of Health. *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance.* 2015. P.3

Categories	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. Provide wrap-around coordinated care for people with complex needs
What services are relevant? ***(Service level matched to individual clinical need and suitability)***	Mainly publicly 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 Psychological services for those who require them	Mainly face-to-face primary care services backed up by Psychiatrists or links to broader social supports. 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 Coordinated, multiagency services for those with severe and complex mental illness
What are the typical workforce requirements?	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: Certificate III or IV equivalent recommended entry point Completion of recognised training in delivery of cognitive behaviour therapy 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 professionals 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 Private psychiatrists and paediatricians involved for some, particularly for assessment and review of clinical needs Peer workforce to complement clinical services provided by other workforce	Central role of private psychiatrists, paediatricians and GPs Psychological therapy provided by psychologists and other allied health professionals Mental health nurses involved in coordinating clinical care and supporting the role of GPs and private psychiatrists Peer workforce to complement clinical services provided by other workforce

Activities not considered in scope for Primary Health Network commissioning of mental health services within a stepped care approach are those which:

- Are not supported by an empirical evidence base;
- Fall outside the scope of primary mental health care e.g. social support;
- Duplicate or replace existing services provided by other organisations, including governments; or
- Are not in line with PHN funding guidelines.

4.1 Workforce competency

The Mental Health Stepped Care Model is based on a multidisciplinary approach. As such, commissioned Providers are expected to have in place an appropriate mix of qualified staff with both formal qualifications and professional experience, who can deliver an appropriate service response across the continuum of acuity.

Health professionals providing the Primary Mental Health and Suicide Prevention Stepped Care Program are recognised health professionals with the qualifications and skills to provide expert care and advice. They must practice in accordance with the relevant professional standards as established by their professional body and/or the regulating and registering authority, Australian Health Practitioner Regulation Authority (AHPRA).

To ensure high quality of service delivery, Health Professionals who deliver these services must:

- be credentialed in the field of mental health, or (to allow for entry of newly trained persons into the field of mental health) under the approved and direct professional supervision of a fully qualified and accredited mental health professional; and
- meet the required qualifications and standards to provide the specified therapies including continuing professional development requirements.
- have completed current, best practice current training relative to priority populations or services being offered

For the delivery of services within Step 4: Moderate Mental Illness and Step 5: Severe Mental Illness, this will be primarily registered, credentialed and recognised psychologists, mental health nurses, mental health social workers, mental health occupational therapists and Aboriginal and Torres Strait Islander mental health workers).

5. Service Delivery Models

5.1 Intake, referral and feedback pathways

Access to Primary Mental Health and Suicide Prevention services will vary. Referrals may come from any source including General Practitioners, Registered Nurses or other health professional or through self-referrals or from family and carers.

Referrals may be subject to an intake process where an assessment is undertaken prior to acceptance or onward referral to the appropriate service or step. Health Services are required to consider how they will align and integrate with intake, referral and feedback processes with other local and regional Health providers and services. For example, Health Services need to consider methods for standardised Pre and Post Treatment outcome assessments and the appropriate tool to be used for the condition or therapeutic treatment. The PMHC MDS requires providers to collect and report outcome measures at pre and post, and appropriate review points, either Kessler 10 or Kessler 5 for adults and young people, and Strengths and Difficulties Questionnaire (SDQ) for children.[2] Health Services can apply alternative outcome measures, however one of the three mandatory tools listed above must be used.

Consumer access to Primary Mental Health and Suicide Prevention services should not be impeded by the absence of a referral from a General Practitioner either in the form of a referral or Mental Health Treatment Plan. However, it is best practice for Health Services to connect with a client's usual General Practitioner to provide appropriate feedback regarding mental health treatment and to ensure continuity of mental and primary health care and service provision.

[2] https://docs.pmhc-mds.com/projects/data-specification/en/v2/data-model-and-specifications.html

Where services are delivered by a mental health nurse under a Severe and Complex contract the supplier must require a GP Mental Health Treatment Plan, or a referral from a psychiatrist or paediatrician, with some flexibility for commissioned service providers to allow provisional referrals to enable service provision to commence while arrangements are made for the client to see a GP in recognition of barriers to timely access to medical practitioners in some regions and by some populations groups. Health Services are required to maintain improved pathways and intake, triage and demand management processes within available resources so that referrals are accepted throughout the contracted period. They must ensure feedback to General Practitioner or other referrer during and at the completion of the client's service, or more frequently for long term clients. While repeated referrals may not be required, where possible/appropriate Health Services will provide a feedback report to the General Practitioner or referrer midway through the client's initial episode of care including forecasting total number of therapeutic sessions required and outlining client's key health and social issues.

Service integration is a requirement of the Stepped Care model. Health Services will be required to provide evidence of health system development as outlined in the Service Order. Evidence of collaboration and integration with other health providers including general practitioners. Evidence of a report sent to the patient's own primary care provider, general practitioner or other referrer.

Community sector engagement is another requirement of the Stepped Care model. Health Services will be required to provide evidence of community understanding of appropriate access to the service(s) and evidence of engagement and partnership with health and human services sector including Aboriginal Services and other vulnerable groups. Health services are required to put the necessary protocols and procedures in place to ensure services are delivered in a culturally appropriate manner.

6. Reporting guidelines

6.1 Quantitative Data

Data submitted by Health Services must comply with the National Minimum Data Set relevant to Primary Mental Health and Suicide Prevention Stepped Care (PMHC-MDS)[3] and submitted by the dates outlined in the Service Order. headspace centres are required to utilise the HAPI system and other data systems as requested.

Performance Targets

Performance targets are calculated on the total number of Occasions of Service provided by the Health Service and are outlined in the Activity Work Plan, as approved by Gippsland PHN.

A time fraction has been allocated for each of Steps 3 to 5 (Mild, Moderate, Severe) to determine an Occasion of Service. An Occasion of Service is defined as an individual session (1:1 between client and health professional) or as an individual session within a defined Group Program of 3 or more people.

An Individual Session is defined as one (1) Occasion of Service. The time fraction allocated will be reflective of the Step for which the Group is being delivered.

A Group Program is calculated as three (3) Occasions of Service. The time fraction allocated will be reflective of the Step for which the Group is being delivered.

The time fraction allocated for an Occasion of Service is reflective of the level of acuity, complexity and care coordination required to support consumers in each step and outlined below:

[3] https://pmhc-mds.com/

Time allocation per Occasion of Service in minutes:

Mild Mental Illness:	60 minutes
Moderate Mental illness:	75 minutes
Severe Mental Illness:	100 minutes

An Occasion of Service includes the following three activities:

1. Therapeutic intervention
2. Coordination and Integration Activities (including step up and down)
3. Administration Time (indirect time)[4]

Health Services will provide to Gippsland PHN monthly data summarising the total number of:

- Individual Occasions of Services for Steps 3 to 5 (Mild, Moderate, Severe)
- Group Programs delivered for Steps 3 to 5 (Mild, Moderate, Severe)

7. Funding guidelines

7.1 Service Order

A Service Order (Contract) between Gippsland PHN and the eligible Health Service will define the terms and conditions to be performed by both parties to the agreement and define the specifications of the Primary Mental Health and Suicide Prevention Stepped Care Program to be delivered by the Health Service.

7.2 Activity Work Plan

Health Services, funded through the Program, are required to complete an Activity Work Plan on a template provided by Gippsland PHN outlining the Health Service's stratification of the population into different needs groups. The components of the Activity Work Plan template include details and evidence of:

- The community's mental health profile and proportional allocation within the different levels of a stepped care model.
- Service delivery and workforce profiles and referral pathways that support greater community access to services.

The Activity Work Plan Template informs the deliverables outlined in the Service Order with Gippsland PHN. Gippsland PHN may request a Health Service to update the Work Plan to capture changes in service delivery or funding. In assessing the Activity Work Plan Template Gippsland PHN will consider:

- How well the content meets the aim and objectives of the Primary Mental Health and Suicide Prevention Stepped Care Program.
- The adequacy of coverage and sustainability of the service delivery model to ensure services are maintained in existing communities.
- Whether the content meets the requirements of the Service Order and the Program Guidelines.

[4] Health Services are not required to separately report indirect time to Gippsland PHN, as this is already captured in an Occasion of Service.

7.3 Workforce acquittal

Commissioned Health Services may have varying employment models that vary from full-time salaried engagement of the Primary Mental Health and Suicide Prevention Stepped Care Program, which may lead to sharing of staff/contractor time across multiple programs. Where this occurs, organisations must ensure that time/services are properly attributed to each program. Organisations must also clearly delineate between Primary Mental Health and Suicide Prevention Stepped Care Program funds (and their use) and funds received from other sources.

Primary Mental Health and Suicide Prevention Stepped Care Program funding should not be used to pay for services funded under other programs such as Victorian State Government funding. Program income and expenditure must be separately reported to Gippsland PHN in the financial statements and reports submitted by the funded organisation under the Terms of the Agreement.