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Northern Queensland
Primary Health Network

Mental Health Stepped Care Services review

Summary Report

November 2022

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Contents

1 Context and Review Objectives

Objectives of this review

Context

Northern Queensland Primary Health Network's (NQPHN) mental health objectives are to:

- Increase access for North Queenslanders to access mental health services appropriate to their individual needs
- Provide North Queenslander primary healthcare providers with an integrated approach to mental health care and suicide prevention
- Commission quality mental health services to improve outcomes for patients.

NQPHN commissions mental health stepped care services (MHSCS) in six areas to achieve these priority objectives. One or more service providers have been contracted to deliver:

1. Central Intake Assessment Triage and Referral services (Connect to Wellbeing model)
2. Psychological Therapies
3. Mental Health Integrated Complex Care (MHICC)
4. Place Based (remote) Psychological Therapies
5. Psychological Therapies for people with mental illness in Residential Aged Care Facilities (RACFs)
6. Digital/telephone - low intensity services.

In line with the Department of Health and Aged Care (DoHAC) program requirements, NQPHN seeks to improve the MHSCS across four performance domains:

- Access to services
- Efficiency of service delivery
- Appropriateness of service delivery; and
- Effectiveness of services delivery.

Objectives

PwC was engaged by NQPHN to conduct a review of the mental health stepped care service (MHSCS) model and the services commissioned as part of it by analysing the current MHSCS model and its elements, including identifying any gaps and identifying opportunities for improvement to inform future decision making and commissioning priorities and approaches. The following four of the six areas were within scope for this review:

1. Central Intake Assessment Triage and Referral services (Connect to Wellbeing model)
2. Psychological Therapies
3. Mental Health Integrated Complex Care (MHICC)
4. Digital/telephone - low intensity services.

To guide the review process, 26 lines of enquiry were developed across the four performance domains.

Purpose of this document

This document provides a summary of review findings against each of the lines of inquiry. As part of these findings this report articulates the implications for NQPHN to inform future commissioning decision making and alignment against broader mental health strategic issues. This includes consideration of opportunities for:

- Joint planning and commissioning with system partners
- Service integration with First Nations services
- Alignment with emerging mental health service models and priorities
- Improved service planning and design of investments, activity, and programs within the MHSCS model that meaningfully improve consumer outcomes.

Limitations of the review

The analysis and findings of this review should be considered in the context of the following limitations:

- The level of detail that was able to be collected, breadth of consultation, and the ability to 'deep dive' into certain elements of the model and data has been shaped by the 3-month timeframe available for this review.
- The absence of established lived experience committees or advisory groups within NQPHN, MHSCS providers and the community at large has made it difficult to engage with consumers and carers of MHSCS safely and thoroughly within the review timelines
- Insight gathered from the Primary Mental Health Care – Minimum Data Set (PMHC-MDS) is impacted by both missing and inaccurate data.
- The scope of this review being limited to four of the six areas of the NQPHN MHSCS model constrains the potential learnings for the other two areas.

Current State

1 Mental health in the NQPHN catchment: a snapshot

- NQPHN has invested $34,445,160 in the MHSCS model over the past 4 years.
- In 2021 the percentage allocations to the various components of the model were:
    - 29% towards Connect to Wellbeing
    - 35% towards psychological therapies
    - 36% towards MHICC services.
- A total of 141 services have been funded.
    - 1 service has been funded to deliver Connect to Wellbeing,
    - 129 have been funded to deliver psychological therapies, and
    - 11 have been funded to provide MHICC
- In 2021 4,364 referrals were processed by Connect to Wellbeing with 4,209 referrals to funded mental health stepped care services (3,966 to psychological therapies and 243 to MHICC).[1]
- In 2021 a total of 4,644 consumers received services from the MHSCS model, of whom 541 (10%) identified as Aboriginal or Torres Strait Islander.

Current challenges with mental health services in NQPHN

Key factors impacting access to primary mental health care services in NQPHN have been identified as:

- Workforce shortages
- Out of pocket costs
- Lengthy wait times
- Lack of health literacy
- NQPHN geography
- Difficulty accessing transport
- Services are not culturally appropriate to meet the needs of First Nations consumers
- Difficulties integrating technology.

2 Stepped Care model expectations for PHNs

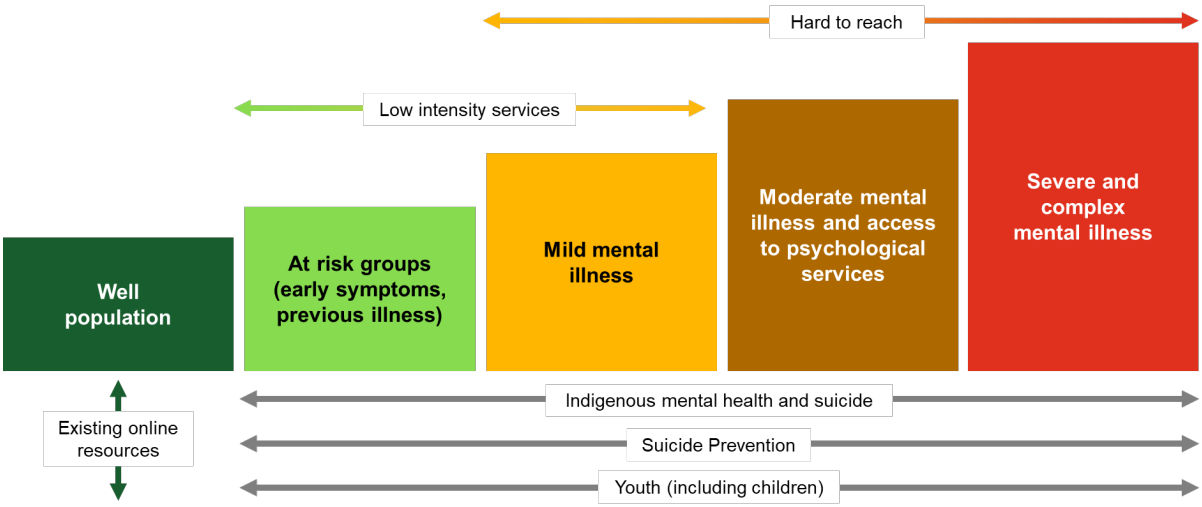
As part of the PHN Primary Mental Health Care Flexible Funding Pool Programme PHNs are expected to deliver primary mental health stepped care to consumers requiring low, moderate and severe and complex intensity services.

[1] Connect to Wellbeing referrals are based on calculations of the number of unique episodes of care assessed by the IATR function each year from the PMHC-MDS. Referrals to MHICC and psychological therapy are calculated based on the unique number of episodes of care that services provided, by organization, within the minimum data set, excluding the IATR service. Psychological therapy provided by subcontractors is calculated using data provided by subcontractors. Given the use of multiple data sources it is possible that several episodes of care that have been referred between providers have been double counted within this analysis, inflating the total number of total funded stepped care mental health services referred into. In addition, the data does not capture referrals to services external to the MHSCS model.

Level of care	Levels of severity most commonly associated with the level of care	Description of clinical services	Broader non-health support services likely to be needed
Low intensity services	Mild to moderate mental illness	Accessed quickly, without need for formal referral, through a range of modalities and involve a few short sessions	Routine social supports and supports targeting situational stressors
Moderate intensity services	Mild to moderate mental illness	Structured, reasonably frequent and intensive interventions	Community supports such as peer support or social participation and/or lifestyle interventions
Severe and complex intensity services	Severe conditions that include high level of risk, disability or complexity	Intensive team-based specialist assessment and intervention with involvement from a range of different mental health professionals	Psychosocial disability support services and community supports, daily living support, social participation or interventions

3 NQPHN MHSCS model

To better meet population needs NQPHN has established a MHSCS model that aligns with DoHAC expectations. The MHSCS model includes a central intake, assessment, triage and referral (IATR) function that refers consumers to services at the level of care most appropriate to their needs



Referral, assessment, and triage process

A single IATR service, Connect to Wellbeing, has been commissioned to provide centralised and consistent assessment, triage and referral of consumers to mental health stepped care services across the region. The role of the Connect to Wellbeing service is to ensure that:

- People are referred to appropriate health and community services
- Resources are effectively targeted
- Duplication is avoided
- Expected levels of unmet demand are managed

In NQPHN's MHSCS model the assessment process may be undertaken by a broad range of mental health professionals including accredited mental health nurses, psychologists, mental health social workers or mental health occupational therapists.

The IATR service is expected to prioritise and manage patient access and referral to appropriate services in addition to onward referrals across the stepped care continuum, including referrals to other levels of stepped care services. As part of this the IATR is also expected to promote "no wrong door" by referring individuals, where appropriate, to clinical mental health services in the public/private sectors, support services in the social and community services sectors, the NDIS, or to Medicare provided services (Better Access), where the presenting needs of individuals are out of scope for the MHSCS model.

Referrals may be made face-to-face, by telephone, electronically, or by a written referral.

4 Current Services by acuity

Low intensity services:

Low intensity mental health services provide psychological interventions to support consumers with or at risk of mild mental illness, supplemented by the role of Head to Health digital supports and integration with existing primary care services. The service providers that deliver low intensity services include the 1300 free call number, counsellors, and support services.

Referrals to low intensity services are not needed to access the 24/7 1300 free call number. This allows for the undertaking of preliminary social health assessments and the referral to up to 6 short-term call back psychotherapy sessions and a follow up session, either virtually or in the consumers local area.

Moderate intensity services:

Psychological therapies enable GPs and primary health workers to deliver moderate levels of care through time-limited and evidence based psychological treatments. In NQPHN this is delivered by subcontracted psychologists and mental health professionals as a complementary program to the Medicare-subsidised Better Access Initiative North Queensland. For consumers whose needs exceed Better Access scope/service caps psychological therapies is available as an additional support.

The moderate service delivery includes an initial course of six counselling sessions, with the consideration for further treatment and an allocation of a supplemental four sessions. On the completion of 10 sessions of treatment, exceptional circumstances can require an additional six sessions, up to a maximum of 16 individual sessions per client, per calendar year.

Severe and complex intensity services:

The service offering of the Mental Health Integrated Complex Care program (MHICC) was re-designed in 2020. In the current model a referral from a GP or a private psychologist is required and directed to the Central IATR system. After being directed, MHICC Nurses deliver case management service offerings. MHICC prioritises person centred and holistic care services such as care coordination, psychoeducation and support to self-manage, family support, recovery planning, physical health monitoring and medication management.

Key offerings and eligibility requirements of NQPHN's levels of care services

Level of care	Key offerings	Eligibility requirements
Low intensity services – digital/telephone services	• Evidence-based psychological interventions • Up to 6 short term call back psychotherapy sessions	• Experience symptoms or be at risk of a mild mental health condition • Meet age requirements - 15+ years old • Reside in the NQPHN catchment area
Mild to moderate intensity services – psychological therapies	• Short-term psychological intervention, including skills training, CBT, and facilitation of referrals to alternative therapies,. • Up to 10 group therapy sessions	• Hold a current healthcare card, low-income health care card or pension card • Have a non-acute mental health condition • Have a mental health treatment plan (MHTP) or a child treatment plan (CTP) or be accepted to a provisional referral • Reside in the NQPHN catchment area
Mental health integrated complex care (MHICC)	• Psychoeducation and self-management support • Family support • Recovery planning • Physical health care and metabolic monitoring • Medication management	• Experience severe mental illness with complex needs • Have two or more aspects of their life significantly impacted by mental illness • Have experienced a hospitalisation for mental health or are at risk of being hospitalised if not supported • Not a current client of HHS mental health services • Expected to need ongoing treatment for 2 years

5 Wait times between referral and service contact

	2017	2018	2019	2020	2021	2022 (YTD)	Total
Referrals processed	0	0	2,067	4,501	4,364	1,690	**12,622**
Mean wait times between referral and service contact (days) - TOTAL	252.1	167.9	31.5	18.1	17.4	9.0	**24.9**
Mean wait times between referral and service contact (days) - MHICC	252.1	167.9	109.0	28.4	26.9	13.2	**78.4**
Mean wait times between referral and service contact (days) - Moderate intensity	No data	No data	28.0	16.5	16.9	8.9	**19.1**

Note: Referral numbers for IATR have been generated by calculating the number of unique episodes of care assessed by the IATR function each year from the PMH-MDS. Wait times have been determined by subtracting the number of days between an episode's initial referral and first service contact. As there are noted data input issues from the years 2017-2019, it is likely that these figures are skewed and not representative of the full situation.

- For all consumers referred and provided care in or after 2017, the average number of days between referral and first service contact was 25 days.[2] For cohorts receiving MHICC the average number of days between referral and first service contact was 78 days.[3] Operational Guidelines state that for consumers receiving psychological therapies or MHICC this should be within 14 days.
- From 2017 to 2022, time delays between referral and first service contact were reduced with average wait times for referrals in 2017 being 252 days, compared to wait times in 2020 of 9 days.[4] This may also reflect delays in consumers acting on their referrals
- Almost half of respondents to a MHSCS consumer and carer survey reported that the wait time to receive care was inappropriate.

[2] PwC analysis of NQPHN Primary Mental Health Care Minimum Data Set (PMHC-MDS)

[3] Ibid.

[4] Ibid.

Summary of leading practices and policy context

1 Insights from leading best practice models of stepped care services

A review of stepped care service models in other jurisdictions was conducted in order to identify innovations and opportunities that may be applicable to the NQPHN MHSCS model. The following jurisdictions were explored:

- The New Zealand Primary Mental Health Stepped Care Model
- Canada: The University of Toronto Stepped Care approach
- Eastern Melbourne PHN Mental Health Stepped Care model
- Gippsland PHN Mental Health and Suicide Prevention Stepped Care Program
- Tasmania: Primary mental health – Stepped Care model
- Western NSW PHN Stepped Care Approach for Mental Health

NQPHN aligns with other stepped care models and shares similar challenges. Review of other models identifies the following considerations:

There is a movement towards joint regional planning and a likely shift towards more co-commissioning of services

There is rapid development of eHealth services and digital capabilities

There is a need to engage with people of lived experience in co-design and co-delivery of services

Service delivery is continuing to build critical person-centred partnerships for effective service delivery

Systems are aiming to deliver integrated, aligned and coordinated care that avoids duplication and inefficiencies.

2 Policies and key documents relevant to the NQPHN MHSCS model

The mental health landscape is undergoing significant reform which will impact the future NQPHN MHSCS model. Key policies, reforms, and documents have been developed both at a state-wide and national level to outline mental health priorities and commissioning landscapes that will form the foundation for future stepped care model arrangements. The following have been used as inputs to the review and inform the recommendations:

- PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance and related materials
- Head to Health policies, reforms and model expansion
- National Mental Health and Suicide Prevention Plan
- Bilateral Schedule on Mental Health and Suicide Prevention: Queensland
- Inquiry into the opportunities to improve mental health outcomes for Queenslanders
- Productivity Commission inquiry into the economic impacts of mental ill-health
- Royal Commission into Victoria's Mental Health System

A summary of implications for NQPHN developed from an analysis of related key policies, reforms and documents is outlined below:

- There needs to be clinical governance collaboration, local delivery pathways and accountability of service providers across the continuum of care

- The use of digital service delivery, and the Head to Health gateway in particular, by both providers and consumers should be encouraged, enabled and integrated within the existing system
- There is a shift towards co-commissioning which forms part of the bilateral agreement between Queensland Government and the Commonwealth, signaling a changed approach to commissioning of mental health services in future
- There is a growing missing middle and stepped care services will need to be well integrated so that these individuals do not fall through service gaps
- There is growing recognition of the need to co-design services with providers and people with lived experience to meet local needs
- There is a strong focus on providing care in the community for as long as is safe and appropriate which will increase reliance on primary mental health services
- Services need to be tailored to individual levels of need and preferences, which means providing access to a variety of modalities and interventions to suit these needs and preferences.

2 Review Findings

Areas of strength:

- The number and proportion of new consumers who identify as Aboriginal or Torres Strait Islander has increased since 2017 and represent 9% of all consumers.
- The MHSCS model reaches consumers experiencing financial disadvantage, high trauma or homelessness that are not able to access MBS funded services.
- Several service providers report an increased uptake of digital and virtual mental health services.
- The average treatment period for consumers is 3.9 sessions which is in line with the Operational Guideline recommendations.
- Dropout rates are low at 5%. For MHICC services it is 6% overall, while for moderate intensity services it is 3%.
- Psychological therapy providers have noted the Connect to Wellbeing IATR function is resourced with well-qualified professionals which builds trust in the effectiveness of the service and referral decision making.
- Service provider compliance with Matched Pair Outcomes has improved (though there is still room for improvement).

Key opportunities:

- The MHSCS model should be redesigned with service providers and people with lived experience to improve access, streamline processes for intake and referral, enable seamless transitions across the care continuum and improve integration across the mental health service system.
- There are opportunities to better integrate the MHSCS model with Head to Health digital resources as well as the Head to Health IATR service.
- More could be done to improve access to MHSCS for target populations including First Nations people.
- NQPHN should explore alternative processes for referrals and access to moderate and severe and complex intensity services that do not rely solely on GPs (e.g. referrals from other providers and/or workforces).
- To improve data quality and enable performance monitoring and service improvement NQPHN should implement minimum data standards, make certain fields mandatory, and make compliance with data capture a condition of service agreements.
- There should be improved communication and coordination with GPs, practice managers and practices throughout the MHSCS model.
- A greater return on investment would be achieved by building the capacity of consumers to self-manage their mental health and wellbeing, and if there was greater access and utilisation of lower intensity services including group therapies, peer support, and models of care that make better use of technology.

In line with the DoHAC program requirements, NQPHN seeks to improve the MHSCS model across four performance domains. Key findings from consultation and data analysis are outlined against each domain.

Access

Context:

- While First Nations people may access the MHSCS model NQPHN has also implemented place-based initiatives to deliver mental health and wellbeing services specifically to First Nations communities. However, place-based initiatives are out of scope of this review.
- Greater mental health literacy and individual capacity through a community supported recovery process is encouraged as part of the delivery of person-centred and holistic services, and supporting self-management,.[5]
- Both the MHSCS model and the Health Needs Assessment target mental health services towards consumers in the catchment requiring low intensity, moderate intensity (psychological therapy) and severe and complex care with the greatest need for vulnerable cohorts.[6]

Findings:

- On average 2,697 new consumers access the MHSCS each year. The number and proportion of new consumers who identify as Aboriginal or Torres Strait Islander has increased and represent 9% of all consumers.
- Access and utilisation of the MHSCS model is limited by three key factors:
    - Limited awareness of the model and the services that are available to access amongst service providers.
    - The role of GPs as 'gatekeepers' to make referrals to services.
    - Limited availability of services for consumers to be referred to for provision of moderate and severe and complex care, especially in rural and remote areas
- Making financial disadvantage a prerequisite to access the MHSCS model is working as intended with providers reporting that a larger proportion of consumers accessing psychological therapies and suicide prevention plans via MHSCS experiencing financial disadvantage, high trauma or homelessness compared to those they provide care for via the Better Access MBS scheme.
- While current consumer cohorts align with the intended target groups of the MHSCS model there remain opportunities to further improve access. Several service providers are working to engage their local communities to increase awareness and access to services.
- Stakeholders perceive MHSCS processes and service delivery could be improved to be more culturally appropriate and safe for First Nations people.
- Stakeholders perceive that MHSCS are not tailored to meet the specific needs of the LGBTIQ+ community.
- Several service providers report an increased uptake of digital and virtual mental health services. To continue to build capacity to self-manage, consumers, carers and the community need to be made more aware of the resources and supports available for people with low intensity care needs.

Opportunities:

[5] North Queensland Primary Health Network, 2020. *Mental Health Stepped care service: Operational Guidelines*

[6] Northern Queensland Primary Health Network, November 2021. *Health Needs Assessment 2022-24*

- The MHSCS model should be redesigned with service providers, people with lived experience, and non-health service providers to improve access and streamline processes for intake, assessment, referral, and step-up and step-down transition.
- Digital resources such as the Head to Health website can help to build mental health literacy and the capacity to better self-manage mental wellbeing.
- Head to Health also has an IATR function with local teams (based on postcode entered when calling this service) working with consumers, carers and family members to find the right supports that are needed. There are opportunities to leverage and integrate with the Head to Health IATR service and reduce duplication.
- Greater awareness of existing resources and increased access to low intensity services would support consumers, carers and the community to better manage their own wellbeing. This could also be aided by an expanded lived experience workforce.
- More could be done to improve access to MHSCS for vulnerable communities, including young people, people experiencing substance use issues, low-income populations and First Nations people.
- There is a need to engage First Nations communities in service design, delivery and evaluation. Opportunities to expand the workforce to include Aboriginal and Torres Strait Islanders should also be explored.
- Work should be undertaken to better understand the mental health needs of the LGBTIQ+ community and the extent to which these are currently being met. Similar work should be done with culturally diverse communities to understand whether their mental health needs are being met.

Appropriateness

Context:

- Consumers seeking access to MHSCS should be able to access services in a timely manner. To access low intensity services a free call number is available 24 / 7. Service agreements stipulate that consumers requiring psychological therapies must be initially contacted within 3 days and offered an appointment within 2 weeks.[7]
- The NQPHN MHSCS model is intended to provide a continuum of care for consumers requiring clinical and non-clinical services, including the ability to step up and down as required. This integrated approach is intended to reduce fragmentation of services, reduce reliance on acute hospital services, and manage growing demand.[8]
- Contracted service providers are required to have a quality management framework in place, including corporate and clinical governance arrangements to manage quality and safety of service delivery.[9]

Findings:

- While the therapeutic interventions offered across the MHSCS model are appropriate there is feedback that gaps exist in terms of the type of modalities that are offered across moderate intensity and severe and complex therapies. There is an opportunity for NQPHN to work with providers, and people with lived experience, to co-design different modalities so that people can be offered intervention types that best suit their preferences.
- While time delays between original referral and service contact appeared to have been improving over time the quality of data captured in rediCASE and analysed as part of the PMHC-MDS make it difficult to draw meaningful insights. Stakeholders suggest wait times remain an issue.
- The PHMC-MDS indicates that mean wait times between original referral and service contact for those presenting with suicide flags in 2022 was 3 days for moderate intensity consumers and 13 days MHICC consumers. However,

[7] North Queensland Primary Health Network, 2020. *Mental Health Stepped care service: Operational Guidelines*
[8] Northern Queensland Primary Health Network, November 2021. *Health Needs Assessment 2022-24*
[9] North Queensland Primary Health Network, 2020. *Mental Health Stepped care service: Operational Guidelines*

there are known issues with this data that make it unreliable for monitoring and tracking response to a suicide flag. Feedback from service providers is that the response to a suicide flag is appropriate and occurring in a timely manner.

- The average treatment period for consumers is 3.9 sessions, which is in line with the Operational Guideline recommendations (2017-2022). For Moderate intensity services the average treatment period was 3.0 sessions and for MHICC services, the average period was 11.3 sessions.
- While the number of sessions taken to achieve an improvement in mental health condition aligns with the NQPHN MHSCS Operational Guidelines, stakeholders indicated that consumers are not always being stepped down as and when appropriate.
- The average number of sessions until treatment concluded and a positive change in condition was recorded was 6.7 sessions for moderate intensity services (which is within the number of sessions outlined for psychological therapies in the Operational Guidelines) and 14.1 sessions for MHICC.
- Dropout rates are low at 5%. For MHICC services it is 6% overall, while for moderate intensity services it is 3%.
- There is limited integration linking intervention steps within the NQPHN MHSCS model. This is driven by a lack of awareness of the services on offer, difficulty navigating cumbersome processes that deter step down, and funding arrangements that do not incentivise collaboration and integration. This suggests model redesign is needed to create seamless step-up and step-down arrangements.
- While clinical governance arrangements exist at the provider level this could be strengthened by having clinical governance across the continuum of care. This would reduce the likelihood of there being gaps in clinical governance as consumers transition between service providers.

Opportunities:

- The MHSCS model should be redesigned with service providers, people with lived experience and non-health service providers, to enable seamless transitions across the care continuum and improved integration across the mental health service system.
- There needs to be a focus on raising awareness of the MHSCS model and the services available to both the community, and to service providers, to improve access.
- NQPHN should explore alternative processes for referrals and access to moderate and severe and complex intensity services that do not rely solely on GPs (e.g. referrals from other providers and/or workforces).
- To improve data quality and enable performance monitoring and service improvement (including wait times and response to suicide flags) NQPHN should implement minimum data standards, make certain fields mandatory, and make compliance with data capture a condition of service agreements.

Effectiveness

Overview:

- Service providers are required to measure clinical outcomes for consumers, as well as their experience of services. This is intended to facilitate continuous improvement while delivering person-centred care.[10]
- The Joint Regional Plan between NQPHN and the relevant HHSs aims to improve the outcomes and experiences of consumers and carers by improving coordination between the organisations that fund and deliver mental health, suicide prevention, and alcohol and other drug services.

[10] North Queensland Primary Health Network, 2020. *Mental Health Stepped care service: Operational Guidelines*

- Commissioning decisions need to be informed by both an understanding of the outcomes to be delivered, and the context of local service delivery and consumer need.

Findings:

- Psychological therapy providers have noted the Connect to Wellbeing IATR function is resourced with well-qualified professionals which builds trust in the effectiveness of the service and referral decision making.
- Matched Pair Outcomes are recorded for 45% of MHICC episodes compared with 48% for moderate intensity (psychological therapy) episodes. While service providers have been improving compliance with Matched Pair Outcome measures over time, there is still room for improvement. NQPHN and services highlighted that the outcome measurement tools used may not be appropriate for certain consumers based on the condition and are not culturally appropriate for First Nations people.
- Several stakeholders suggested that consumers find it difficult to access and navigate the MHSCS model. The numerous assessment and referral processes can be difficult to understand and navigate leading to a negative experience and seeking care elsewhere.
- Of all consumers who had matched pair outcome measures 17% recorded an improvement in condition (represented by an improvement in K10 acuity classification), 79% had no change and 4% had a negative change. This suggests less than half of consumers are having a tangible improvement in condition over the course of treatment.
- Consumer experience could also be improved by co-designing different modalities and interventions to suit the various needs and preferences of consumers.
- Overall feedback is that the community and service providers within the NQPHN catchment are not aware of the MHSCS model or how to engage with it which could be addressed through including raising awareness and marketing as part of service agreements with providers.
- GPs are a key component of the NQPHN MHSCS model. However, GPs have reported that they are often unaware of what happens to their clients once they are referred to the MHSCS model.
- Shared care arrangements across the MHSCS model are currently limited – this is particularly important for those consumers with chronic and complex conditions who require shared care and service coordination.

Opportunities:

- Outcome data should continue to be monitored to determine whether additional sessions available for care provision are required.
- NQPHN should work with DoHAC and other PHNs to find the right outcome measurement tools, including for specific consumer cohorts.
- MHSCS needs to effectively engage with service providers across the continuum of care while being mindful not to create unnecessary processes that burden providers in order to foster buy-in
- There should be improved communication and coordination with GPs, practice managers and practices throughout the MHSCS model.
- To better facilitate shared care, changes and improvements to information sharing, referrals, and eligibility could be explored. Shared care could also be facilitated with the use of coordinator roles across the MHSCS model
- NQPHN should look to strengthen continuous improvement practices across the MHSCS model as part of the next phase, including regularly monitoring consumer and carer experience survey.

Efficiency

Context:

- The NQPHN 2022-24 Health Needs Assessment demonstrates the demand and need for mental health and wellbeing services within the NQPHN catchment.[11] The resource limitations faced by each service provider (and the mental health system more broadly), make effective and efficient care imperative and require the finite allocation to be best matched to need.

- The MHSCS model is intended to reduce costs to the health system over time by improving mental health and wellbeing outcomes and reducing demand for more acute and tertiary mental health services. However, it is reasonable to expect that costs of service delivery increase with intensity and based on location.

Findings:

- There are finite resources available for commissioning of services. Both NQPHN, and service providers within the catchment, are aware of both the demand and need for MHSCS and the funding and resourcing constraints.

- It is estimated that the average cost to NQPHN per service is between $349 for moderate intensity care (i.e. psychological therapies) and $381 for MHICC. Feedback from other jurisdictions suggest that a reasonable cost per service contact may be within the range of $150-$300. This is less than the unit cost estimated for the NQPHN MHSCS.
- The average cost to achieve a positive change in condition is $2,356 for moderate intensity services and $5,372 for MHICC. Higher average costs for MHICC are associated with the number of sessions required to achieve an improvement in condition which aligns with the severe and complex care needs of this cohort.

- Service providers reported there is excessive administrative burden at each level of the MHSCS model. Reducing the number and complexity of steps required to refer and triage consumers would free up time for delivery of care and make it easier for consumers to access and transition between the services they need.

- In reviewing the allocation of funds across the footprint and to the intensity types, there is a misalignment between current allocations and population health needs. The largest proportion of funding is allocated to MHICC while the greatest need is for low and moderate intensity services.

Opportunities:

- Appropriate and timely step-down transitions to lower intensity services would improve efficiency of the MHSCS model.

- A greater return on investment would be achieved by building the capacity of consumers to self-manage their mental health and wellbeing, and if there was greater access and utilisation of lower intensity services including group therapies, peer support, and models of care that make better use of technology.

- Improving efficiency of the NQPHN MHSCS model should also focus on improving the design of intake and referral services to be more timely and less cumbersome, including removing the reliance on GPs for referrals at multiple points of the consumer journey, and leveraging the new intake processes available through Head to Health.

11 Northern Queensland Primary Health Network, November 2021. *Health Needs Assessment 2022-24*

3 Recommendations for NQPHN

Four key recommendations are proposed for NQPHN:

1. Re-design the MHSCS model to improve access, integration and effectiveness
2. Review and enhance the clinical governance approach
3. Assess the comparative efficiency of NQPHN commissioned services and appropriateness of funding allocations across the region and by service type
4. Continue to drive data quality enhancements to inform ongoing continuous improvement.

The following recommendations for the NQPHN MHSCS model seek to drive greater accessibility and integration for future stepped care service models.

1. Re-design the MHSCS model to improve access, integration and effectiveness

There is an opportunity to re-design the MHSCS model with a view to driving increased integration and access. NQPHN should take a co-design approach to inform understanding of local contexts, community needs and service provider preferences to inform future commissioning decisions, including co-designing the service model and program logic as part of future commissioning activities. The re-design of the service model should include:

- Consideration of opportunities to enhance the intake and assessment service, including enabling integration with other intake components of the mental health system such as Head to Health and tertiary intake services.
- Exploring opportunities to enhance the range of service offerings across the stepped care continuum and across the NQPHN region to better meet consumer needs.
- Implementing process improvements to further enhance accessibility and integration, including streamlining step-up and step-down processes, enforcing limitations on session numbers and amending consumer eligibility requirements to increase accessibility.
- Exploring opportunities to drive stronger integration of the model by commissioning integrated elements of the model, rather than individual services.
- Continuing to drive joint planning and commissioning, with a view to developing a shared stepped care model to reduce system duplication and better target NQPHN services to meet system needs.
- Building workforce capacity and capability through exploring alternative workforces to deliver care where appropriate including a lived experience workforce.
- Undertaking ongoing market engagement to inform understanding of market strengths and gaps, workforce requirements, opportunities to use digital resources and increase the use of lower acuity services and to build a community of practice.
- Improving communication and coordination elements of the model, and exploring shared care opportunities, to ensure service providers are working together with consumers to meet their goals.
- Leveraging the commitments and integration opportunities through the Joint Regional Wellbeing Plan.

2. Review and enhance the clinical governance approach

In addition to enhancements to the MHSCS model through re-design, there are opportunities to enhance the clinical governance approach for the model. This includes:

- Enhancing consumer and carer engagement, potentially by establishing a lived experience advisory group to seek advice, co-design and co-deliver mental health and wellbeing services.
- Ensuring services are culturally appropriate and available to all communities across the region, including for First Nations consumers.
- Establishing regular meetings and forums to connect with GPs, practice managers, nurse practitioners, HHSs and ACCHOs to increase knowledge, support involvement in the MHSCS model and integration between providers.

3. Assess the comparative efficiency of NQPHN commissioned services and appropriateness of funding allocations across the region and by service type

There is a need for targeted analysis to assess the efficiency of NQPHN commissioned services against comparable benchmarks, including other PHN service costs and those of comparable sectors. This analysis will also need to consider the appropriateness of funding and best value for money interventions (including making the most of technology). This can

be used by NQPHN to determine whether services commissioned represent value for money and are available to those that most need support.

4. Continue to drive data quality enhancements to inform ongoing continuous improvement

Access to quality and timely data is critical to better understand service demand, capacity and trends. NQPHN will need to identify and implement improvements to the capture and analysis of data to draw meaningful insights that can inform program improvements. This includes continuing ongoing work to enhance data quality, as well reviewing the use of outcome measurement tools.

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