Hāpai te Tūmanako - Raise HOPE Implementation Plan

Stepped Care Document Review

Updated 12 May 2015

INTRODUCTION

This document reviews a number of key local, national and international plans and reports that contain information about Stepped Care and other relevant Service Models. The review process has included the extraction of all relevant Stepped Care information from each document, the identification of the key points and a final summary.

The purpose of the review is to:

- Improve our understanding of what Stepped Care models are and how they work.
- Provide examples of how a Stepped Care model can be implemented.
- Identify how high a priority the implementation of Stepped Care is in the Mental Health and Addictions Sector.
- Support the next stage of the Stepped Care Project which is the development of a draft model followed by sector consultation on the draft for feedback and input.
- Provide information that will support Stage 2 of the Stepped Care project which is the development and completion of the Stepped Care Implementation Plan.

The documents included in this review are:

⇨ Rising to the Challenge: The Mental Health & Addiction Service Development Plan 2012-2017	Ministry of Health	2012
⇨ Blueprint II: Improving mental health and wellbeing for all New Zealanders	Mental Health Commission	2012
⇨ Raise HOPE - Hāpai te Tūmanako Strategic Plan 2012-2015	Southern DHB	2012
⇨ Raise HOPE - Hāpai te Tūmanako Implementation Plan 2014-2019	Southern DHB	2014
⇨ Southern District Suicide Prevention Action Plan 2015-2018	Southern DHB	2015
⇨ New Zealand Suicide Prevention Action Plan 2013-2016	Ministry of Health	2014
⇨ Southern Strategic Health Plan Piki te Ora	Southern DHB	2015
⇨ Stepped Care Proposal	Kerry Hand	2015
⇨ On Track: Knowing where we are going	Te Pou & Platform Trust	2015
⇨ Integrating Primary Care into Behavioural Health Settings	Dr Martha Gerrity (US)	2014
⇨ Better, Sooner, More Convenient Health Care in the community	Ministry of Health	2011
⇨ Commissioning Stepped Care for people with common mental health disorders	NHS (UK)	2011
⇨ Individualised funding for New Zealand mental health services: a discussion paper	Te Pou	2014

Report/Plan	Description	Stepped Care/Service Model Content	Key Points
Rising to the Challenge: *The Mental Health & Addiction Service Development Plan 2012-2017* **Author:** Ministry of Health **Date:** 2012	Ministry of Health Plan to set the direction for mental health and addiction service delivery across the health sector over the next 5 years.	▪ Building infrastructure for integration between primary and specialist services. ▪ Support fit-for-purpose service configurations. ▪ Increase emphasis on early intervention. ▪ Ensure value for money. ▪ Collaborative cross-sector planning, funding and delivery. ▪ Changes to models of service delivery that will be necessary to expand access to, and better integrate, mental health and addiction responses for people experiencing high prevalence conditions - key actions in making this happen will be to further develop and strengthen the stepped care approach. In this approach services intervene in the least intrusive way, from self-care, right across the primary, NGO and DHB continuum, in order to get the best possible outcomes, enabling entry and exit at any point depending on the level of need. The aim of the stepped-care approach is to provide a seamless, integrated response whereby people receive support that is appropriate and timely, and access holistic packages of care that bring together support across sectors and silos. ▪ Enhance the delivery and integration of specialist mental health and addiction services within primary care. ▪ Develop and implement a primary mental health and addiction service delivery framework that addresses mental health and addiction needs in primary care and recognises ethnic disparities. The service delivery framework will include a service matrix detailing the range and mix of primary care service types and interventions. It will be based on a stepped-care model that enables people to rapidly receive the level of care that is appropriate to their need. ▪ Mental health and addiction services (NGO & DHB) will enhance the delivery and integration of specialist mental health and addiction services within primary care. As part of a stepped-care approach, provide support and advice to primary care and other general health services.	⇨ **Endorses the Stepped Care approach.** ⇨ **Emphasis on early intervention.** ⇨ **Advocates for integrated primary and secondary services and the appropriate infrastructure (IT) to support it.** ⇨ **Outcome focused.**
Blueprint II: *Improving mental health and wellbeing for all New Zealanders* **Author:** Mental Health Commission **Date:** 2012	Mental Health Commission 10 year vision to improve the mental health and wellbeing of all NZers that encompasses all of government and provides guidance on what is required to meet future needs and how to make the changes called for.	▪ We need to make substantial changes to the level and mix of services provided as well as where and when we intervene. It means a greater role for primary care and changes in the way our workforce is used. An important component of this change will be the full implementation of a 'stepped care' approach - intervening in the least intensive way from self care and across primary, community and specialist services to get the best possible outcomes. ▪ Stepped care is a structured mechanism for achieving increases in efficiency. The use of this model must span primary, community and specialist services and create opportunities for collaboration with other organisations; for example, those in the social welfare, education and justice sectors. ▪ A stepped care approach involves: o Using the least intrusive treatment required to meet presenting need. o Making available interventions with differing levels of intensity.	⇨ **Advocates for the Stepped Care approach.** ⇨ **Increased role for Primary Care and Community Care.** ⇨ **Requires cross-sector collaboration.** ⇨ **Requires the re-orientation of the mental health and addictions workforce.** ⇨ **Need for different funding, contracting and commissioning arrangements.**

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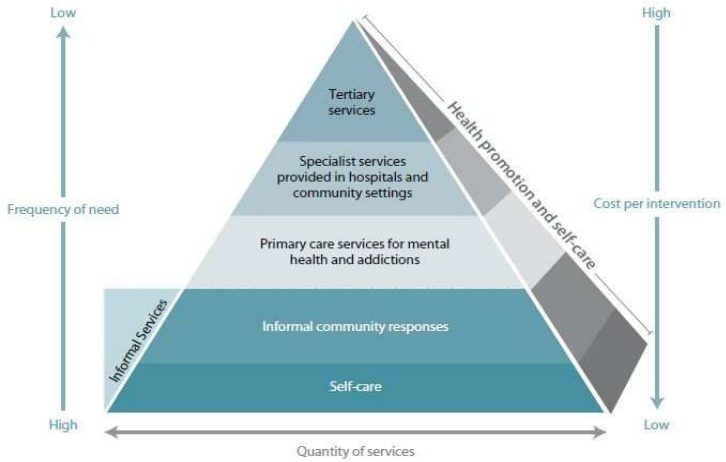
		o Matching people's needs to the level of intensity of the intervention. o Entry and exit at any point. o Using robust tools to routinely collect outcomes data to support people's journey into, through and out of services. o Having clear referral pathways between different levels of intervention. o Supporting self-care as an important aspect of managing demand across primary, community and specialist care settings.  *Source: Adapted from the World Health Organization.*[31] ▪ Using the stepped care model should result in an integrated response - where people receive support that is appropriate and timely - and holistic packages of care that bring together support across sectors and silos. ▪ As part of implementing the stepped care approach we need to reconsider what services are provided, and where they are provided. We need less provision of services that are known to add limited value (for example, generic or standard case management) and more provision of services that are known to add value (for example, talking therapies). We need to ensure that clinical expertise is more accessible to support community and primary care. Through this re-orientation of the specialist mental health and addiction workforce we can greatly increase access rates and shift the focus of intervening earlier in the life course. Over time this will prevent downstream increased need and enable gradual reinvestment in earlier intervention. ▪ To support the move to a stepped care, no wait, integrated approach, we will need different funding, contracting and commissioning arrangements.	

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Raise HOPE - Hāpai te Tūmanako Strategic Plan **Author:** Southern DHB **Date:** 2012	Southern DHB Mental Health and Addictions Strategic Plan for 2012-2015.	▪ Integrated Tiered Service Model - The mental health and addiction sector has many consumers who require, and access, multiple services. Consumer outcomes will be improved as these services are better connected and integrated. This is particularly consistent with Strategic Direction 4 - working as one sector, with a whole of systems approach. There will be a tiered services model with services dispersed across the district within communities as much as practicable. Groups of providers will work together. The highest priority will be well co-ordinated care - regardless of where services are based, or who is providing them. If more complex or specialist care is required, care will be delivered from the next tier up. This may include a mixture of outreach services that come to communities and/or services located in more urban areas. The highest tier - the most complex care - will be provided by inpatient services and regional tertiary services. Across every tier - and every service - there will need to be good communication strategies including a common language, common assessment tools and joint care planning. ▪ Prevent mental illness and intervene early. ▪ Intervene in targeted, effective ways across the life course. ▪ Locate support close to consumers and in communities. ▪ Work as one sector, with a systems approach. ▪ Constantly improve sector quality, capability, productivity and capacity. ▪ We need to improve the range and capability of services provided in primary and community settings. We need to increase the integration between the primary services that generally see people with mild to moderate conditions and those of the specialist services that see moderate to severe conditions.	⇨ **Advocates for an 'integrated tiered service model'.** ⇨ **Promotes early intervention and services 'close to home'.** ⇨ **Requires integration between primary care and specialist services.**
Raise HOPE - Hāpai te Tūmanako Implementation Plan **Author:** Southern DHB **Date:** 2014	Southern DHB Mental Health and Addictions Plan to implement Raise HOPE from 2014-2019.	▪ We need to do things very differently if we are to extend across a broader range of mental health and addiction responses and develop a no wait system which provides early and timely responses. To achieve the 5 high level outcomes of Hāpai te Tūmanako- Raise HOPE requires changing the level and mix of services provided in our district as well as where and when we intervene, more services will be delivered in the primary/community setting and there will need to be changes in the way our workforce is used. An important component of this change will be the full implementation of a stepped care approach - a framework through which to provide better access to services. It involves the introduction of a tiered approach to service provision - intervening in the least intensive way from self care and across primary, community and specialist services to get the best possible outcomes, freeing up capacity at specialist tiers of the service to provide effective treatments for those with more complex needs. To provide safe, high quality services in communities will require a multidisciplinary approach. A Stepped Care service model will support the majority of the population accessing services, i.e. early intervention and increased access to resources at the primary and community level. A smaller percentage will need to access specialist	⇨ **The development & implementation of a Stepped Care Model for the mental health and addictions sector in the Southern District is a priority project identified in Raise HOPE.** ⇨ **Requires a change in the level and mix of services currently provided.** ⇨ **More services to be delivered in primary/community settings.** ⇨ **Will mean changes in how the workforce is used.** ⇨ **Managing the transition between tiers of treatment fundamental to the models success.**

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		secondary services with optimum assessment, intervention and throughput, and an even smaller percentage will require access to tertiary specialist inpatient and crisis resolution services from time to time. A stepped care continuum will need to have clear pathways and be integrated across primary, secondary and tertiary services to ensure effective access and ease of movement between the different levels of service provision, with high volume, low intensity interventions being provided to those with the least complex difficulties. Subsequent steps are defined by increasing levels of complexity. Interventions used should have the best chance of achieving positive outcomes with the least intrusive manner and should be regularly reviewed and stepped up or down as needed. It will require streamlining referral pathways to ensure a seamless progression. Identifying processes to support and manage the transition between the tiers of treatment is fundamental to the successful implementation of this model.	
Southern District Suicide Prevention Action Plan 2015-2018 **Author:** Southern DHB **Date:** 2015	Southern DHB Plan for district wide activity including suicide prevention, post-vention processes and education and training.	▪ The Suicide Prevention Coordinator acts as a resource as services and organisations develop pathways that support the timely and appropriate access to services for those people who attempt suicide or at risk of suicide. This work is mandated via the Raise HOPE Implementation Plan, and will have a whole of system focus and include further development of suicide prevention risk assessment and management discharge and follow-up in early intervention services (eg the Brief Intervention Service, GPs and Practice Nurses).	⇨ **A 'whole of system' approach will improve access to services for people at risk of suicide.**
New Zealand Suicide Prevention Action Plan 2013-2016 **Author:** Ministry of Health **Date:** 2014	Ministry of Health Plan to coordinate national suicide prevention activity.	▪ Improve services and support for people experiencing mental health problems and alcohol and other drug problems - primary care services and emergency departments are the two critical intervention points in the health system that can reach people with mental health problems and/or self-harm behaviour who are at risk of suicide.	⇨ **Highlights the need to support people at risk of self harm or suicide in primary care and emergency settings.**
Southern Strategic Health Plan Piki te Ora **Author:** Southern DHB **Date:** 2015	Southern DHB strategic plan for the planning and delivery of all health services in the Southern District for the next 10 years.	▪ The Southern strategic direction will ensure a sustained focus on: o Quality improvement o Reprioritising low value spending o Horizontal (primary and community) and vertical (primary, community and specialist) integration of services o Delivery of the right care, at the right time, in the right setting o 'Upstream' prevention and early intervention o Service co-ordination for high needs patients and their families o Facility and service networking, to provide better support for rural hospitals, and smoother patient journeys to and from the major hospitals	⇨ **Review and improve systems of care.** ⇨ **Requires further integration of services.** ⇨ **Primary care to be peoples 'health care home'.** ⇨ **Further implement 'Alliance Models' to improve collaboration, integration and to drive change.**

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		o Modernising of models of care to cater for the prioritised future health needs of the catchment populations o 'Right-sizing' of workforce and facility capacity and capability, within a high performance environment. ▪ Integrate services to ensure patient journeys are smooth through efficient and effective care pathways, and that the system is easy to use for everyone. ▪ Strengthen population health approaches, and the core role of general practice as the 'health care home' for patients within the primary and community team. ▪ Alliances - health systems are seeking to strengthen integration of their various components, in order to contribute to improved patient access, population outcomes, and resource use. An important step in this across New Zealand has been mandating of 'alliance' relationships between the DHB and PHOs operating in its area. Extension of the collaborative planning and decision-making relationships established and fostered through alliancing will be an important feature of the future Southern health system. Early actions will include: o Application of the alliancing model through locality networks that will foster collaborative planning and delivery for local communities o Establishment of service level alliances to plan and develop services in prioritised areas, including community mental health, and health of older people services. ▪ Improve the quality of the care and services we deliver using quality improvement principles and methodologies so that waste is reduced, value for money is improved and savings contribute to bringing our revenue and expenditure into alignment, complemented where necessary, by tight cost management, improved productivity and different resource allocation patterns.	
Stepped Care Proposal **Author:** Kerry Hand **Date:** 2015	Independent view of what a Stepped Care Model should look like in the Southern District and how it can be implemented.	▪ Primary, secondary and public health services are merged. ▪ Nearly all services delivered by 'Multi Function Area Teams (MFATs)'. They are based in 20-25 centres across the Southern District providing a full range of clinical services to their local population. Staff size to be approximately 10-40. ▪ MFAT's can be operated by different organisations including the DHB, Community Health Trusts, Primary Health Practices or NGOs. ▪ MFAT's will have multi-disciplinary teams and will improve access to services. They will focus on prevention, resiliency building and outcomes for consumers, families and communities. ▪ MFAT's to use the same 'branding' and identical internal systems (IT, quality, HR, reporting etc). ▪ Implement a new 'systems of care' model by creating a new entity to fund and oversee the delivery of mental health and addiction services by MFATs. ▪ Tertiary services (inpatient, forensic) continue to be delivered much as present. ▪ Collaborative funding arrangements between Southern DHB and other government agencies (who have an impact on the determinants of health) including Education, Child Youth & Family and Ministry of Social Development. New entity developed to contract unified services.	⇨ **Most mental health and addiction services to be delivered in the community.** ⇨ **Services delivered by multi-disciplinary teams in 'Multi Function Area Teams'.** ⇨ **Requires a new model for the planning, funding and delivery of services.**

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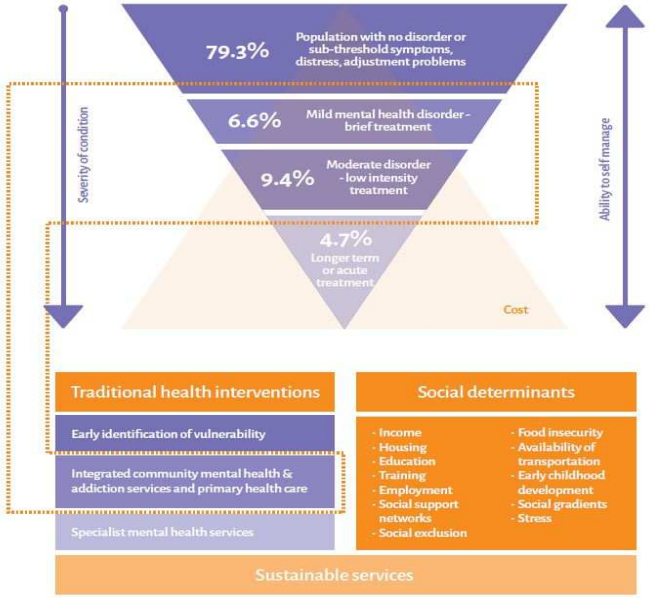
On Track: *Knowing where we are going - co-creating a mental health and addiction system New Zealanders want and need* **Author:** Te Pou & Platform Trust **Date:** 2015	A road map for mental health and addiction NGOs to change their models of service delivery to meet the future needs of consumers and their families.	▪ The Stepped Care model reflects the prominence of the stepped care model in the service demand estimates used in *Towards the Next Wave* (Health Workforce New Zealand, 2011). It is based on a stepped care model for primary MH&A originally developed by Dowell, Morris, Dodds and McLoughlin (2012), which has been modified to incorporate the following features. o The main focus is on the needs of the population and not on services, hence the inverted pyramid with the majority of people situated at the top. o The traditional primary care space has been expanded to include mental health and addiction NGO services. o Mental health and addiction NGO services provide a wide range of community services across the continuum of care. o Services intervene early to help avoid the need for more intensive services. o The appropriate level of service intervention is constantly being matched to the diverse and changing needs of the person and their family/whānau. o People have the ability to manage their own health and wellbeing at any stage. It is the role of MH&A services to coach people in how to grow this ability. o Traditional health interventions are complemented by the social determinants of health (eg, housing, welfare, employment, etc.) o Sustainability of health and social services is critical to the effectiveness of this model.  	⇨ **Advocates for the Stepped Care approach.** ⇨ **Primary care and NGOs should provide services across the continuum of care.** ⇨ **Changing the system will have major implication for the workforce.** ⇨ **Focus on early intervention and prevention.** ⇨ **Need for different funding, contracting and commissioning arrangements.**

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		▪ Changing the system - the situation requires changes in workforce practices at three levels. o Placing greater emphasis on services partnering with individuals and their families/whānau, to help them identify their strengths and increase their capacity to manage their own health and wellbeing within a wider community context. o Changing the current configuration of services (eg, introducing new models of care, shifting the emphasis from specialist services to community/primary care, making greater use of multidisciplinary teamwork, integrating services, increasing collaboration between services, piloting innovative service delivery arrangements and eliminating the needless cycles of assessment and referral). o Giving equal weighting to the social determinants and cultural aspects of health, as well as the medical aspects. In addition, there needs to be changes to the systems and structures that underpin the current service delivery model (eg, developing a new commissioning framework, streamlining contracting arrangements, using new contract reporting requirements and introducing new human resource practices that support different ways of working).	
Integrating Primary Care into Behavioural Health Settings: *What works for individuals with serious mental illness* **Author:** Dr Martha Gerrity **Date:** 2014	A US (Utah) report that identifies and evaluates the evidence for Behavioural Health Integration models for serious mental illnesses.	▪ Behavioural health integration (BHI) is a patient-centred approach that addresses all the health needs of patients. ▪ While there is a robust evidence base supporting the effectiveness of integrating behavioural health into primary care settings for adults with depression and anxiety disorders, the evidence base for models that target individuals with serious mental illness and substance use disorder has not been the focus of prior reviews. This report evaluated 12 studies (adult only). ▪ The use of fully integrated care or enhancing collaboration through care management appears to improve mental health outcomes and us of preventive services for adult patients with bipolar disorder and other serious mental illness. The interventions used to integrate care or enhance collaboration required additional staff, training and ongoing of care managers in the studies reviewed. Early evaluation data indicates suggests that these interventions may reduce costs and decrease health care utilization for adults with serious mental illness. ▪ Common among all programmes is the use of integrated data and population health tracking systems and robust referral networks for physical and mental health care and social services coordination.	⇨ **Research provides some evidence that interventions in primary and community settings can improve outcomes for people with serious mental illness.**
Better, Sooner, More Convenient Health Care in the community	Describes the new policy direction of increased and improved coordination	▪ The report outlines the important role of primary health care and promotes opportunities for further collaboration between primary care and secondary care providers. It promotes prevention, better access, better quality, less waiting, more community services and closer to home.	⇨ **Advocates for increased integration between primary and secondary health services.**

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Author: Ministry of Health **Date:** 2011	and collaboration between primary and secondary care services. The report also includes examples of innovative programmes around NZ.	▪ Case studies outlined in the plan include: o GP call centre, virtual appointments and increased collaboration (Waikato) o New telemedicine resources (West Coast) o Practice nurse visits for over 75s and individualised care plans (Palmerston North) o Integrated Family Health Centre (Mount Wellington) o Individual Care Plans for people with chronic illnesses (Opotiki) o Medication reviews for complex patients (Wairarapa) o New electronic tools for referral and access to diagnostic testing (Auckland) o Falls prevention programme for older people (Christchurch) o Primary Options for Acute Care (POAC) (Auckland) o Tele-health monitor (East Coast) o Collaborative GP-DHB care management initiative (South Auckland) o Clinical Family Navigators (East Tamaki) o GP and low cost dental services at an NGO (Auckland) o Increased collaboration and clinical governance between primary and secondary health services (Horowhenua) o The 'Restorative Programme' coordinated by GP and other health professionals (Canterbury)	⇨ **Supports the popular mantra of 'prevention, better access, better quality, less waiting, more choice and close to home'.**
Commissioning stepped care for people with common mental health disorders **Author:** NHS National Institute for Health and Clinical Excellence (NICE) **Date:** 2011	A guide for planners, funders, clinicians and managers to identify and implement high-quality and evidence-based stepped care services for people with common mental health disorders.	▪ The guide promotes the partnership approach to commissioning services for people with common mental health disorders. ▪ The guide recommends commissioning for outcomes - principally increasing the proportion of people with common mental health disorder's who are identified, assessed and receive treatment and the proportion that go on to make a clinically significant improvement or recover. ▪ Common mental health disorders are defined as: depression; generalised anxiety disorder; mixed depression and anxiety; panic disorder; obsessive-compulsive disorder; phobias; social anxiety disorder (social phobia); post-traumatic stress disorder. ▪ The guide recommends that a stepped-care model is used to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. In stepped care the least intensive intervention that is appropriate for a person is typically provided first, and people can step up or down the pathway according to changing needs and in response to treatment. Commissioning services using the stepped-care model is likely to be cost effective because people receive the least intensive intervention for their need. If a less intensive intervention is able to deliver the desired positive service-user outcome, this limits the burden of disease and costs associated with more intensive treatment. Service users may begin their journey at any step of the pathway, in accordance with their needs. Timely referral to higher or lower steps may be appropriate and cost effective for some people. A study of psychological intervention services shows that services that	⇨ **The Stepped Care Service Model has been successfully implemented by the NHS in England and Scotland for almost 10 years.** ⇨ **It is a model for services supporting people who have 'common mental health disorders'.** ⇨ **It has a focus on outcomes for service users.** ⇨ **The model requires some flexibility in how interventions are provided to service users and their families.** ⇨ **Vital that robust systems for outcome measurement are in place.**

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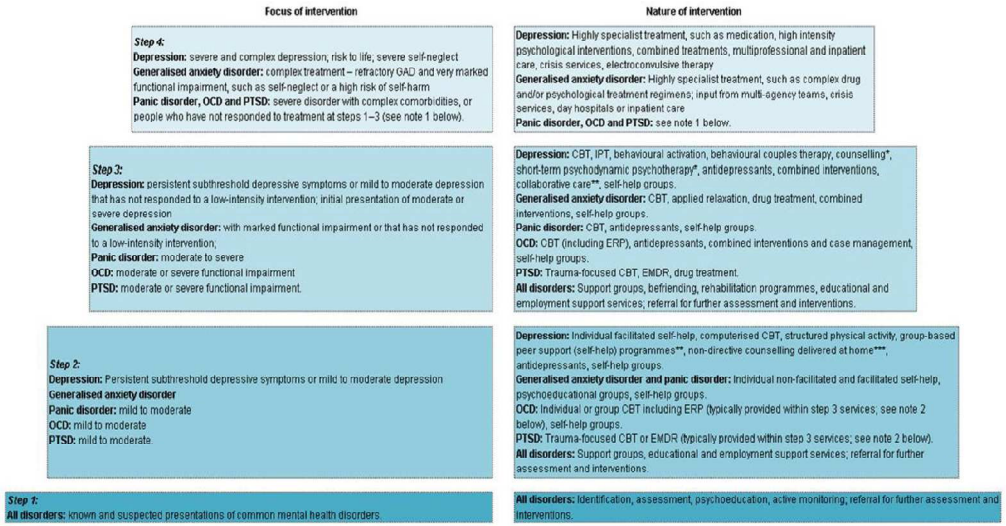
comply with NICE guidance and provide stepped care have better service-user outcomes and improved recovery rates. Commissioners and their partners should develop integrated care pathways that promote stepped care. When commissioning services using the stepped care model, commissioners should ensure that local systems allow for some flexibility in how interventions are provided, with the crucial factors being the patterns of local need and whether a service provider is competent to provide a particular psychological and/or pharmacological intervention.

- The guidelines identify four steps in their stepped care model:



- The guide recommends that primary and secondary care clinicians, managers and commissioners collaborate to develop local care pathways that promote access to services for people with common mental health disorders. It states that responsibility for the development, management and evaluation of local care pathways should lie with a designated leadership team, which should include primary and secondary care clinicians, managers and commissioners. Commissioners should develop, or enhance existing, multiagency partnerships to lead on developing and monitoring local care pathways for people with common mental health disorders.
- The guide recommends that local care pathways should have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. Measuring outcomes, progress, recovery and relapse is vital to ensure that people's treatment is reviewed, and where appropriate stopped, in line with the stepped-care model, if

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		there are signs of deterioration or no indications of improvement. ▪ The guide also includes: How to develop local care pathways; Service Level Outcomes; Inclusive & Accessible Services; Assessing Service Levels; Needs Analysis; Service Components for Stepped Care (specifying steps 1,2,3,4 and other service models); and Service Specifications.	
Individualised funding for New Zealand mental health services: a discussion paper **Author:** Te Pou **Date:** 2014	A paper to provide information that will support discussions about individualised funding options for the NZ mental health and addiction context.	▪ Individualised funding is a payment arrangement that enables people to choose the care provision they receive and manage those services themselves. It is a mechanism for purchasing support services where the person can manage the resources allocated to them. In countries, such as the United Kingdom, individualised funding has been a crucial aspect of personalisation, in which the focus is on meeting service user needs in ways that work for them, and where people are in charge of arranging and managing their own support services. It has been suggested that individualised funding supports individuals to have more choice and control over their lives, and this contributes to their wellbeing. ▪ Individualised funding is now available to some people using disability services in New Zealand. In New Zealand's mental health and addiction sector, the most common funding allocation methods reported by planners and funders are the rollover of historical contracts or use of evidence of effectiveness to reprioritise services and allocate funds (Mental Health Commission, 2010). Packages of Care may be the closest approach to individualised funding used in mental health. Available in primary and secondary care, Packages of Care is a funding mechanism aimed at tailoring support to meet individual needs. However, funding stays with the service not the person. ▪ A study by the Mental Health Commission (2010) identified a range of concerns with current mental health funding arrangements in New Zealand including: a focus on input and outputs rather than effectiveness; funding tied to secondary care rather than early intervention; poor service integration between primary and secondary; and lack of funding flexibility. Some of these concerns were echoed in *Blueprint II* (2012) which called for more personalised care, stronger partnerships between service users, family and providers, and greater alignment between the funding of disability and mental health services (Mental Health Commission, 2012b). A recent article in *NZ Doctor* reports that community services (NGOs) are being "driven into the ground" due to a lack of additional funding to offset cost increases (Platform Trust, 2014). ▪ In general, outcomes for people and their families accessing individualised funding are positive. Most people report increased ability and flexibility to choose a wider range of services to address their health needs. Increased satisfaction with service delivery and fewer unmet needs have been noted in evaluation studies of individualised funding mechanisms. Recipients have reported better psychological wellbeing and greater motivation and confidence than those receiving usual care (Davidson et al., 2012; Forder et al., 2012). ▪ However, most evaluation studies also identified a range of factors that negatively impacted on	⇨ **National and international evidence supports the benefits and positive outcomes for consumers of individualised funding arrangements.** ⇨ **Primarily used in the disability sector in NZ, it is rarely used in the mental health and addictions sector.** ⇨ **Unclear what the impact is on service quality, access, service providers and the workforce.** ⇨ **Proposes that the next step could be the implementation of small scale pilots in urban, provincial and rural settings.**

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		outcomes. These include: paternalistic attitudes of staff limiting people's access to individualised funding (particularly access by people experiencing mental health conditions); lower access rates for more at-risk population groups such as black and ethnic minority groups in the United Kingdom and Aboriginal and Torres Strait Islanders in Australia; heightened stress as a result of managing a personal or individual budget; and insufficient resourcing and administrative support. ▪ Evaluations of individualised funding programmes have revealed a number of programme features that support successful implementation. Key components to successful implementation include: provision of good information; active outreach to marginalised or at risk groups; transparent decision making regarding resource allocation; availability of ongoing third party support to assist with the management of finances and employment relations; supportive staff attitudes and the willingness to pass control to the person using services; adequate funding including costs of related administration; and careful policy development and planned implementation. ▪ It is also important to acknowledge that evaluation studies have tended to focus on the health and wellbeing outcomes of only those people who are eligible to receive health and social care services. It is unclear what impact the widespread use of individual funding has on the overall availability of health and social care support services. This is likely to be a source of uncertainty and anxiety for some New Zealand health services considering individualised funding. Some New Zealand disability providers question what would happen to the employment market and predict that changes could mean that more staff will have to be employed on a temporary or casual basis in response to fluidity of demand (Matthews, 2013). ▪ Given this understandable uncertainly about the impact of individual funding on the overall supply and quality of health and social support, if this model was considered further it would be very important to include key stakeholders (service users, families and whānau, providers, cultural leaders and staff members) in related planning and policy development from the outset. ▪ Policy and planning development would also need to consider whether sufficient ongoing funding could be made available to ensure sustainability. Individualised funding models require significant administrative investment, particularly upfront. In both Australia and New Zealand the costs associated with individualised funding were underestimated, forcing host agencies to work to unrealistic schedules. An international evaluation study of individual funding reported resistance and aversion to risk among teams working with mental health service users or with older people. However, in the last decade New Zealand has invested in developing recovery competencies (O'Hagan, 2001) as well as developing and implementing the *Let's get real* framework of knowledge , skills, values and attitudes needed to support a service user-centred New Zealand mental health and addiction workforce.	

SUMMARY:

Summary of key points identified in this review are:

- ⇨ The Stepped Care Model is commonly referred to as *'a tiered approach to service provision - intervening in the least intensive way from self care and across primary, community and specialist services to get the best possible outcomes, freeing up capacity at specialist tiers of the service to provide effective treatments for those with more complex needs'.*
- ⇨ The accepted/popular version of the model is the 'Stepped Care Triangle' which is able to illustrate the levels of care in relation to the population, their needs and the available services.
- ⇨ The Stepped Care Model is endorsed in the majority of literature reviewed as part of this project.
- ⇨ The Stepped Care Model is being successfully implemented by the National Health Service (NHS) in England and Scotland. There are some 'pockets' of activity around New Zealand that support Stepped Care.
- ⇨ An increased role for Primary Care is supported in all of the literature.
- ⇨ Prevention, early intervention and integrated mental health services are highlighted as a priority in most of the literature.
- ⇨ There is a focus on 'value for money' and 'outcomes' for service users, families and communities.
- ⇨ Different funding and service delivery models may need to be explored including individualised funding to improved self management, choice and outcomes.
- ⇨ Implementing Stepped Care has considerable implications for the current and future workforce.
- ⇨ Implementing Stepped Care requires that a robust and comprehensive data collection framework is in place to measure performance and service user outcomes.
- ⇨ Implementing Stepped Care requires streamlined referral pathways and well managed transition processes between the different tiers/levels of service.
- ⇨ Implementing Stepped Care requires a comprehensive review of what services are currently being provided and where they are provided.
- ⇨ Implementing Stepped Care may require changes to the funding, contracting and commissioning systems and structures currently in place.

- END -