Hāpai te Tūmanako -

Raise HOPE Implementation Plan 2015-2020

The Southern Stepped Care Model

December 2015

Contents

Background & Purpose

In 2012 the first Strategic Plan for the Mental Health and Addictions sector in the Southern District was completed. Raise HOPE - Hāpai te Tūmanako Strategic Plan 2012-2015 was the culmination of 18 months of work led by Southern DHB in collaboration with service users, family/whānau, services and stakeholders.

In 2014 the Implementation Advisory Group completed the Hāpai te Tūmanako - Raise HOPE Implementation Plan. The purpose of the plan was to identify and prioritise the steps required to achieve the sectors strategic goals and vision. To achieve the vision requires considerable change across all parts of the mental health and addictions sector.

Developing and implementing a Stepped Care service model is identified as a priority project. In February 2015 a project plan was developed by Southern DHB outlining the steps that would be taken to develop and implement the Stepped Care service model. The plan was signed off by project sponsor Sandra Boardman, Executive Director, Southern DHB Planning and Funding. A working group of Network Leadership Group members was established with additional expertise sourced from outside of the group (see page 18). The group held its first meeting in April 2015.

The scope of this Stepped Care model does not include services for older people. Alliance South is developing an Older Persons Strategy for all Southern DHB funded health services that support older people across the Southern District. This will include some services that support older people with mental health and/or addiction conditions. Any linkages-alignment between the Older Persons Strategy and the implementation of Hāpai te Tūmanako - Raise HOPE will be reflected in the activity of relevant work-streams and projects.

The purpose of this document is to describe the Stepped Care model. An implementation plan for the Stepped Care model will be developed, with wide input from the sector using a rapid improvement process, in the first quarter of 2016. There will be further opportunity in the second quarter of 2016 for feedback from the sector, as well as from service users and their families and whānau, before the Stepped Care model and implementation plan is finalised.

WHY a Stepped Care Model?

One of the priority projects in the Hāpai te Tūmanako - Raise HOPE implementation plan is the development and implementation of a Stepped Care Model for the mental health and addictions sector in the Southern District.

*"Develop a **Stepped Continuum of Care** model where most people access services in the community/primary care setting, with some needing to access specialist and inpatient services from time to time."*

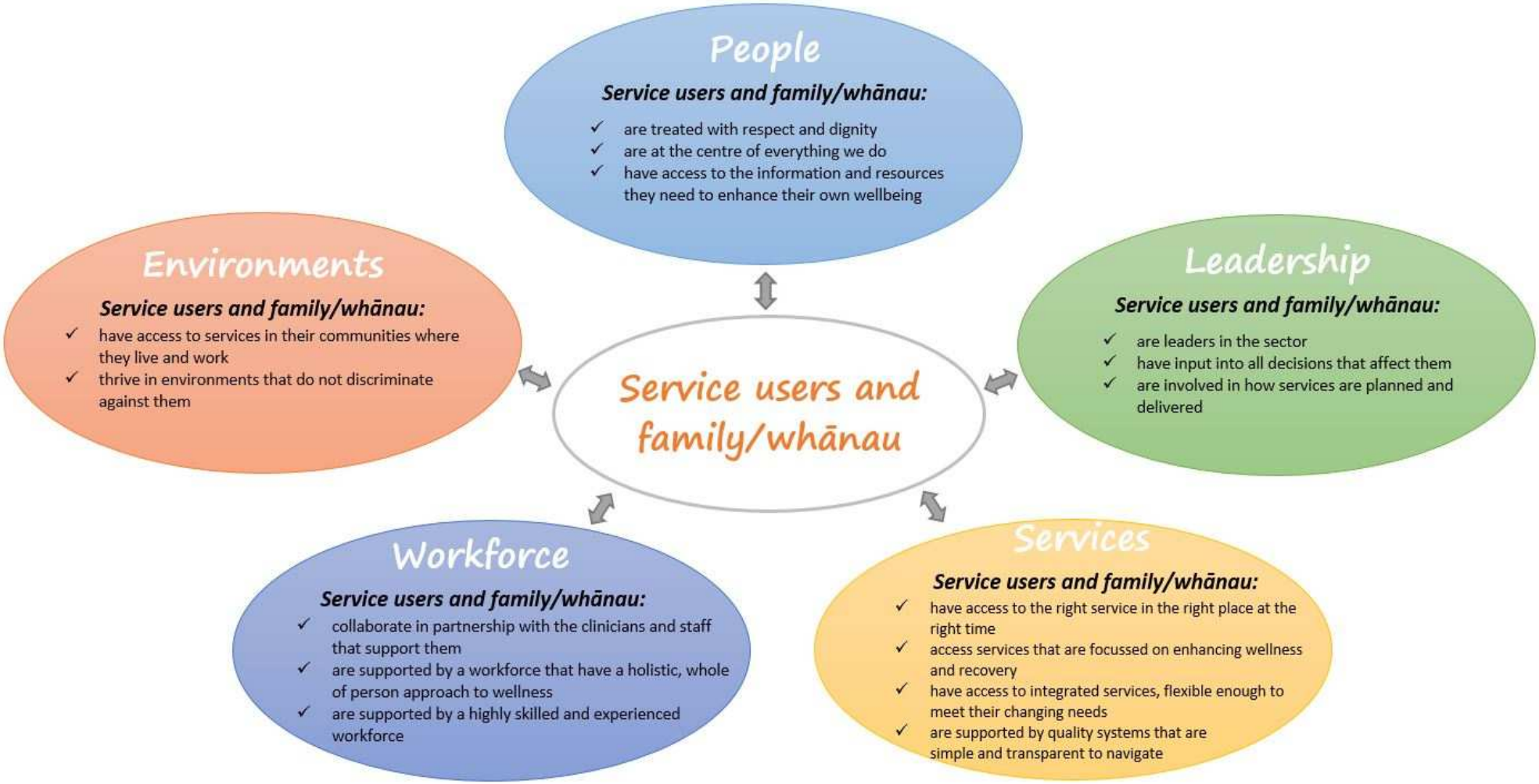
Currently there is no established service model or framework in the Southern District for how mental health and addiction services are planned, funded, delivered and evaluated. If we are to achieve the vision we have for service users and family/whānau we have to change how we currently work. This will have implications on the level and mix of services provided as well as where and when interventions and services are delivered.

A Stepped Care approach is nationally and internationally acknowledged as an effective mental health and addictions service model. Aspects of the approach are being used in parts of New Zealand and it is being successfully implemented in a number of health systems around the world. In New Zealand the approach is promoted and endorsed by the Ministry of Health, the Mental Health Commission, Mental Health Foundation and Platform Trust.

Stepped Care is characterised by 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 for service users and family/whānau. Interventions have the best chance of achieving positive outcomes with the least intrusive manner and are regularly reviewed and stepped up or down as needed. Crucial to the models success are the processes that support and manage a service user's transition between the different steps of support and treatment. The model is designed to ensure that people have access to **'the right service, at the right time in the right place'.**

Our Vision

We want all people to achieve their optimum health and wellbeing. The stepped care model aims to make it easier for people to get the right service at the right time in the right place. People who are distressed can quickly access appropriate holistic care in their community which is right for them. Family and whānau are encouraged and supported to be part of the wellness journey, also with the right support in place for them. Every agency who can help with a person's wellness journey will help coordinate support and work in collaboration to assist that journey.



WHAT does the Southern Stepped Care Model look like?

The Stepped Care model for Southern DHB Mental Health and Addiction services identifies five steps of service delivery. Interventions are delivered at each step with differing levels of intensity to meet the different needs of every service user. Services will intervene early to help avoid the need for more intensive interventions. Services will use the least intrusive support and/or treatment required to meet the presenting need and have clearly defined thresholds to decide who should access support at each step. People have the ability to manage their own health and wellbeing at any step. A key role of mental health and addiction services is to coach and empower people to grow this ability.

Under the stepped care model any door is the right door. Regardless of where or how people contact services they will be connected with the right service to support them. People can start anywhere in the model and some people may need multiple steps of care at the same time, if these are addressing different mental health and addiction problems. Should their situation change, clearly defined referral processes and pathways will ensure that they move seamlessly between different steps of intervention should they need to, and how they exit services.

The inverted pyramid (figure 1 below) illustrates how the model is structured. At each step services are matched to the specific needs of every service user and family/whānau.

Step 1 services include a broad range of informal and formal community supports and resources available to the population at any time. Most people in the community do not require services or are able to self-manage their condition by accessing the information and support they need.

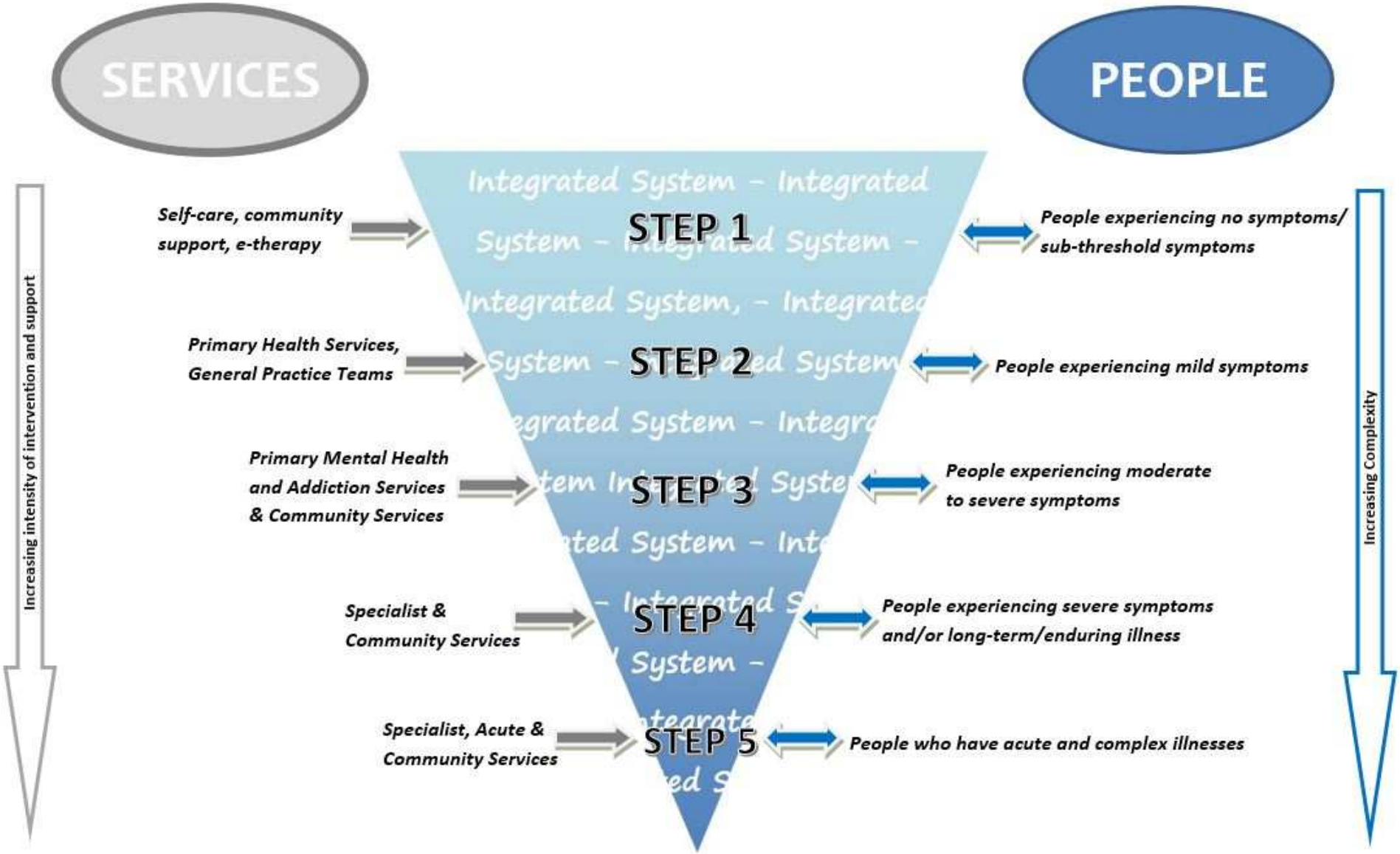
Step 2 services are delivered in primary health and community/NGO settings and support people who are experiencing a mild mental health and/or alcohol and drug condition. This is where most people already receive the advice, care and treatment they need to stay well.

Step 3 services are delivered in primary and community settings and support people who are experiencing moderate to severe mental health and/or alcohol and drug conditions. Step 3 services include child and youth and adult services, Maori services, needs assessment and service coordination, community support, rehabilitation and vocational services and family/whānau services.

Step 4 services are delivered in hospital and community settings and support people who are experiencing severe mental health and/or alcohol and drug conditions. Step 4 services also include community based residential services that support people who live independently in the community with longer-term and enduring conditions.

Step 5 services are delivered to people with severe mental health and/or alcohol and drug problems experiencing acute and/or complex illnesses. Emergency and after-hour services are available to people in crisis, and inpatient services for people who require short-term hospital based support and treatment.

Figure 1 - The Southern Stepped Care Model



STEP 1 - Self Care & Informal Community Responses

Step 1 services include a broad range of informal and formal community supports and resources available to the population at any time. Most people in the community do not require services or are able to self-manage their condition by accessing the information and support they need.

There are a number of factors in the community that prevent people from getting unwell. These include being physically well, connected with family, friends, professional and social networks, drinking alcohol either not at all or in moderation, being drug-free, and being perceived as a contributing valued member of society.

The majority of people in the community either have no symptoms or are able to identify the resources and support they need in community settings to look after themselves. There are a range of options available to people who want to know more or who are concerned that they (or a loved one) are struggling or becoming unwell. Local and national services and resources are available - they include:

- ⇨ Public health services - deliver health promotion/population health programmes and initiatives
- ⇨ National health promotion services - deliver population health and health promotion initiatives including the National Depression Initiative, Health Promotion Agency, Like Minds-Like Mine, Suicide Prevention Information New Zealand (SPINZ) and Mental Health 101
- ⇨ Community groups - provide support, advice, information and resources
- ⇨ Publicly funded government agencies - provide a broad range of services that support individuals and families/whānau. They include Child, Youth & Family Services, Counselling Services, Special Education and School Counsellors
- ⇨ Local support and self-help groups - provide peer support, self-care tools and programmes, advice, information and resources
- ⇨ National support services and resources - includes telephone helplines and counselling services, on-line resources, e-therapy and information and advice (e.g. Healthline, Lifeline Aotearoa, Kidsline, Youthline, Suicide Crisis Helpline, Depression Helpline, Alcohol and Drug Helpline)
- ⇨ Private providers - who work on a fee-for-service basis. Includes counsellors, therapists, family therapists and spiritual healers

Many of these services and resources provide a gateway into primary health and community services. Improved awareness about mental health and addiction conditions and about support groups and services improves the likelihood that people will access the support they need, or encourage a family member, friend or colleague to seek help.

Step 1 Goals

- ⇨ More people will have improved health literacy, awareness of services, and understanding of mental health and addiction conditions.
- ⇨ More people will have the information and resources they need to take care of their own wellbeing.
- ⇨ Increased awareness about suicide and improved ability to identify and support people at risk of suicide.
- ⇨ More people will engage with self-help and support groups.
- ⇨ More people will access self-help information, resources and e-therapy in the community and on-line.
- ⇨ Communities are more resilient with less stigmatisation and discrimination.

STEP 2 - Primary Health Services

Step 2 services are delivered in primary health settings and support people who are experiencing a mild mental health and/or alcohol and drug condition. This is where most people already receive the advice, care and treatment they need to stay well. Support is available from general practice teams and community providers. Primary health services are delivered in a range of different settings including general practices, youth-one-stop-shops, university campuses and other community venues.

People experiencing mild mental health and/or drug and alcohol issues have persistent symptoms that are impacting on their psychological functioning and well-being. This may include (but is not limited to), loss of pleasure in daily activities, sleep disturbances, impact on interpersonal relationships. People continue to participate and attend to meaningful activities, but they described mild to moderate levels of distress (as measured on a normed distress scale).

The majority of the population already seek the advice or treatment they need from health services in their local communities. People want to access care that is close to them in settings they are familiar and comfortable with. A Stepped Care approach means that people will receive the most appropriate level of support and treatment they need for the condition they present with. Because primary health services are often the first point of contact for most people, they have a vital role in providing prompt and early interventions that ensure issues are dealt with quickly and effectively. Primary health services also have an important role in preventing un-wellness. This means providing people with the information, advice and tools for them to manage their own wellbeing and to ensure they have the confidence and knowledge to access help in the future should they need it.

Primary health services are a vital part of the wider mental health and addiction sectors 'one system of care' and ensure that the personal health needs of service users are also addressed. This approach creates an environment where health professionals and services in the community are actively working with one another to better collaborate, integrate and coordinate health care. The 'one system of care' approach is implemented by all services working in the mental health and addictions sector and means that anyone engaging with services experiences a consistently high standard of care, reduced duplication, easy movement between services, and access to clear and concise information and resources that support their recovery.

Step 2 Goals

- ⇨ Any door is the right door - anyone contacting a primary health service will be provided with the information they need to connect them with the right service.
- ⇨ Services will be fully integrated - providing a coordinated and holistic response to the needs of service users and families/whānau.
- ⇨ Services will be outcome focussed - working in partnership with individuals to enhance wellness and achieve the best outcomes for them.
- ⇨ More people will experience improved and timely access to services and greater flexibility regarding their care.
- ⇨ More people will have the information and resources they need to take care of their own wellbeing.

STEP 3 - Primary Mental Health and Addiction Services & Specialist Community Services

Step 3 services are delivered in primary and community settings and support people who are experiencing moderate to severe mental health and/or alcohol and drug conditions. People access the care they need in their local communities where they live and work. Step 3 services include child and youth and adult services, Maori services, needs assessment and service coordination, community support, rehabilitation and vocational services and family/whānau services.

People who are experiencing moderate to severe difficulties with mental health and/or addiction problems have persistent psychological symptoms that impacts on their ability to conduct their lives in a meaningful way. They are likely to have a diagnosable disorder, such as depression, anxiety, post-traumatic stress and substance use. They have problems with psychosocial functioning. Levels of distress are in the moderate range (as measured on a normed distress scale).

Primary mental health and addiction services include general practice mental health and addiction teams and brief intervention services. The teams operate from GP practices, medical centres and other community venues.

Primary mental health and addiction services also include a broad range of specialist community based services that support service users and families/whānau including Maori services, needs assessment and service coordination, community support, alcohol and drug services, rehabilitation and vocational services and family/whānau services.

Step 3 Goals

- ⇨ Any door is the right door - anyone contacting primary mental health and addiction services and community services will be provided with the information they need to connect them with the right service.
- ⇨ Services will be fully integrated - providing a coordinated and holistic response to the needs of individuals and families/whānau.
- ⇨ Services will be outcome focussed - working in partnership with individuals to achieve the best outcomes for them.
- ⇨ More people will receive their care in the community living independent, socially inclusive lives.
- ⇨ More people will experience improved and timely access to services and greater flexibility regarding their care.
- ⇨ More people will have the information and resources they need to take care of their own wellbeing.
- ⇨ Fewer people require higher intensity interventions and fewer re-present to mental health and/or addiction services.

STEP 4 - Specialist & Long-Term Services

Step 4 services are delivered in hospital and community settings and support people who are experiencing severe mental health and/or alcohol and drug conditions. Step 4 services also include community based residential services that support people who live independently in the community with longer-term and enduring conditions.

People experiencing severe difficulties with mental health and/or addiction problems have complex presentations and their ability to conduct their lives in a meaningful way is severely impacted on, with severe loss of day-to-day functioning. This may have been of relatively recent onset, or recurrent presentations, or possibly longer-term difficulties in which the person's needs are met at lower levels of intensity for periods of time. They have high levels of distress (as measured on a normed distress scale) and may have co-existing problems.

Specialist services include child and youth, adult services and forensic services and also regional services. Specialist regional services are Southern DHB funded services that are delivered out of the district (child and youth inpatient services and alcohol and drug residential care and treatment services) or by specialists brought into the district (eating disorders, maternal mental health and forensic services).

People with long-term enduring mental health and/or alcohol and drug conditions have a range of community services available including supported accommodation, supported landlord services, adult rehabilitation residential services, alcohol and drug residential treatment services, rehabilitation and vocational services, planned respite care, family/whānau support and needs assessment and service coordination.

Step 4 Goals

- ⇨ Any door is the right door - anyone contacting specialist services will be provided with the information they need to connect them with the right service.
- ⇨ Services will be fully integrated - providing a coordinated and holistic response to the needs of individuals and families/whānau.
- ⇨ Services will be outcome focussed - working in partnership with individuals to achieve the best outcomes for them.
- ⇨ More people will receive their care in the community, living independent, socially inclusive lives.
- ⇨ Fewer people will require higher intensity interventions and fewer re-present to mental health and/or addiction services.

STEP 5 - Specialist Acute and/or services for highly complex needs

Step 5 services are delivered to people experiencing acute and/or complex illnesses. Emergency and after-hour services are available to people in crisis, and inpatient services for people who require short-term hospital based support and treatment.

People who are experiencing highly severe and/or acute difficulties with mental health and/or addictions are highly distressed. They may be unable to look after themselves in a safe or appropriate manner and they may have withdrawn from many facets of their lives. Their psychological and psychosocial well-being is severely impacted upon and they may be a risk to themselves or others. Their diagnoses are likely to be complex, possible with co-morbidities and formulations of their difficulties are multi-faceted.

Step 5 Goals

- ⇨ Any door is the right door - anyone contacting acute mental health and addiction services will be provided with the information they need to connect them with the right service.
- ⇨ Services will be fully integrated - providing a coordinated and holistic response to the needs of individuals and families/whānau.
- ⇨ Services will be outcome focussed - working in partnership with individuals to achieve the best outcomes for them.
- ⇨ More people will receive their care in the community living independent, socially inclusive lives.
- ⇨ Fewer people will require higher intensity interventions and fewer re-present to mental health and/or addiction services.

HOW are we going to implement Stepped Care?

To successfully implement the Stepped Care model will require change across a range of sectors including population health, primary health and all parts of the mental health and addictions sector in the Southern District. It will require us as a sector to critically review and evaluate how we work now and to agree on a shared vision for the future.

An implementation plan documenting key tangible actions and assocoiated timeframes will be developed using a rapid improvement process. A range of people from the sector, including clients, their families and whānau, will design how the services for each step will work. This will include mapping current client journeys, and the systems and processes that support the journey, and then reshaping the system and processes to improve client journeys.

WHEN will we know we've achieved our goals?

Supporting the implementation of the Stepped Care model will be the development of an outcomes framework to monitor and measure progress. The framework will be developed as part of the process to complete the Stepped Care Implementation Plan and will include the following components:

- ⇨ Targets - performance targets will be identified at every stage of the implementation process and will be used to measure and monitor progress.
- ⇨ Outcome Measures - to assess progress and achievement a set of outcome measures will be identified for the duration of the Stepped Care implementation process. The outcomes will measure how service users, family/whānau, and services are being impacted by the implementation of the Stepped Care model.
- ⇨ Reporting Template - an agreed format will be used to document and present outcome updates and reports to relevant stakeholders.
- ⇨ Timeframes - specific timeframes and milestones will be identified and agreed.

Glossary

- **ADULT -** Age 20+
- **ASSESSMENT-** A formal process completed by a health professional which gathers information regarding someone's state of mind, their health and their personal circumstances.
- **BRIEF INTERVENTION -** Refers to either a one-off, or several sessions between a mental health/alcohol and drug professional and a service user to provide support and treatment.
- **CEP -** Co-Existing Problems refers to anyone who has both a mental illness and an addiction.
- **CHILD & YOUTH -** Age 0-19 (up to 24 for some client groups).
- **COMMUNITY SERVICES -** Services that are close to people's homes - situated in the communities where they live and work.
- **DISCHARGE:** The formal process that a clinician/service implements when someone is well enough to finish their treatment and leave a service.
- **E-THERAPY-** E-therapy (electronic therapy) refers to on-line programmes and resources that provide service users and family/whānau with information regarding mental health and addictions, self-care techniques and therapeutic tools that support someone's recovery.
- **INPATIENT CARE -** The care of service users who require admission to a hospital facility.
- **MILD -** Mild mental health conditions include commonly diagnosed mental health problems including depression, anxiety and phobias.
- **MODERATE TO SEVERE -** Moderate to severe mental health conditions include severe depression, post-natal depression, bipolar affective disorder, obsessive-compulsive disorder, eating disorders and drug and alcohol addiction.
- **MULTI-DISCIPLINARY TEAM (MDT) -** Refers to a team of health care professionals who work either directly or indirectly with a service user (e.g. Nurse, Occupational Therapist, Social Worker, Support Worker, Counsellor, Psychologist, Psychiatrist).
- **NETWORK LEADERSHIP GROUP (NLG) -** The NLG is a sector-wide governance group comprising of an Independent Chair and senior managers and decision makers responsible for leadership, and coordinating the overall strategic function of the mental health and addictions sector in the Southern district including the implementation of Hāpai te Tūmanako - Raise HOPE.
- **NGO -** Non Government Organisations are community based service providers.
- **PATHWAYS -** Refers to the series of steps that a service user experiences during their care or treatment with one or multiple services.
- **PRIMARY HEALTH -** Traditionally the first level of care that most people access when they are unwell.
- **PRIMARY MENTAL HEALTH & ADDICTION TEAM -** A multi-disciplinary team of health care professionals that support and treat people in a community setting.
- **REFERRAL -** The formal process of a service user having part or all of their care passed-on to another clinician and/or service.
- **RESIDENTIAL CARE -** The care of a service user in community based accommodation.
- **RESPITE CARE**: Short term community based care that provides short-term breaks (can be planned or emergency) for service users and their carer(s).
- **SCREENING -** Screening is a shorter version of an assessment which provides the health professional with an overview of someone's current situation and whether there are any immediate risks or safety concerns.
- **SEVERE ILLNESS -** Complex psychological illnesses.
- **SPECIALIST SERVICE -** Any mental health and alcohol and drug service that provides treatment from a mental health and addiction clinician(s).
- **STEPPED CARE -** A tiered approach to service delivery that provides the right service, in the right place at the right time.
- **TREATMENT -** Clinical and therapeutic care and interventions delivered to someone with a diagnosed mental health and/or alcohol and drug condition.

Stepped Care Working Group Membership

Louise Carr - Chief Executive Officer, Pact

Grant Cooper - Team Manager, Otago Mental Health Support Trust

Sandy Dawson - General Manager, Supporting Families Southland

John MacDonald - Chair, Network Leadership Group

Karen Ramsay - Allied Health Director, Southern DHB Mental Health, Addictions and Intellectual Disability Service

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Dr Brad Strong - Clinical Director, Southern DHB Mental Health, Addictions and Intellectual Disability Service

Tracey Wright-Tawha - Chief Executive Officer, Nga Kete Matauranga Pounamu Trust

Richard Harris - Project Manager Raise HOPE Implementation, Southern DHB Planning and Funding