



WAPHA
WA Primary Health Alliance

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PERTH NORTH, PERTH SOUTH,
COUNTRY WA

An Australian Government Initiative

Mental Health Primary Care:

The WAPHA framework for
Integrated Primary Mental Health Care

WA Primary Health Alliance
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Acknowledgements

WAPHA acknowledges and pays respect to the traditional owners and elders of this country and recognise the significant importance of their cultural heritage, values and beliefs and how these contribute to the positive health and wellbeing of the whole community.



Australian Government

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Contents

1	A case for change	5
2	Stepped Care	6
3	Whole Person, Whole Place, One System	7
4	Transforming Primary Mental Health Care	8
5	The Model	9
6	Measuring Outcomes	11
7	What Can We Do	11

Introduction

WA Primary Health Alliance (WAPHA) is committed to advocating and supporting innovation in primary care. WAPHA works with key partners on shared health priority areas to improve equity and health outcomes for the State's diverse communities.

From July 1 2015, WAPHA took on the role of operating the three Western Australian Primary Health Networks (PHNs) - Perth North, Perth South and Country WA.

PHNs are a Federal Government health initiative, established with the key objective of increasing the efficiency and effectiveness of health services for patients, particularly those at risk of poor health outcomes, and improving co-ordination of care to ensure patients receive the right care in the right place at the right time.

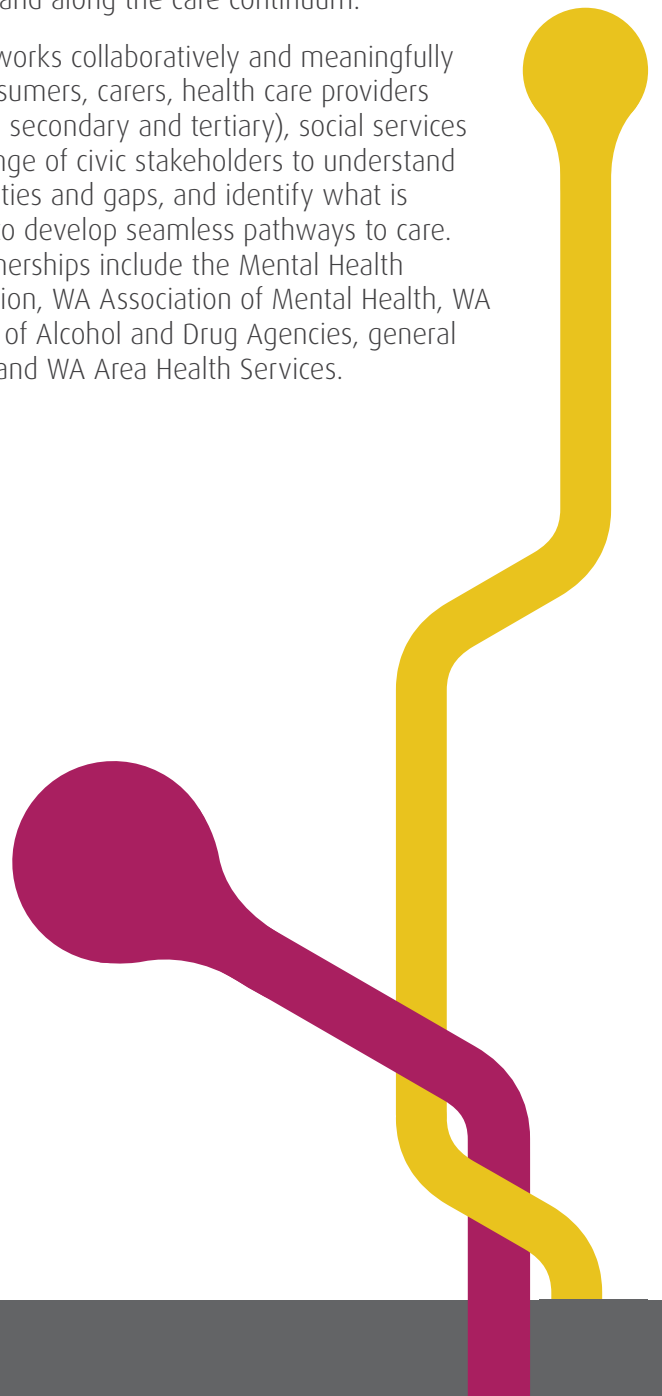
Good mental health is fundamental to the wellbeing of individuals, families and communities and primary care plays an important role in contributing to improved outcomes. High prevalence mental health conditions such as anxiety and depression are amongst the most common reasons for presentations with the health care system. People with comorbid issues, including problematic alcohol and drug use, as well as severe and persistent mental health conditions, are frequently in contact with General Practitioners (GPs) and other support services. A robust and integrated primary care sector can help provide the foundation for more effective and efficient mental health care for our community.

The approach is focused on responding to the evidence about what works:

- intervening early
- enhancing support to those whose current access is limited, and
- better servicing those with a high level of unmet need

At the heart of this whole-of-system integration approach for WAPHA is improving capacity and capability in primary care and general practice. While effective primary care is one necessary component of local self-sufficiency, on its own it is not enough. Solutions to address complex health and social issues need to be owned collectively, and no single service can provide the answer. Improving outcomes requires a joint approach to improve efficiency and effectiveness across systems and along the care continuum.

WAPHA works collaboratively and meaningfully with consumers, carers, health care providers (primary, secondary and tertiary), social services and a range of civic stakeholders to understand complexities and gaps, and identify what is needed to develop seamless pathways to care. Key partnerships include the Mental Health Commission, WA Association of Mental Health, WA Network of Alcohol and Drug Agencies, general practice and WA Area Health Services.



A Case For Change

“There is substantial evidence that a lack of integrated prevention and management strategies contributes to greater burdens of chronic illness and disability, greater health care costs, and a range of other avoidable social and economic costs.”

Beyond the Fragments: Preventing the Costs and Consequences of Chronic Physical and Mental Diseases

The Australian health care system is challenged by the rising burden of chronic disease, an ageing population (numerically and structurally), increasing costs of providing health care, growing health inequity and poor alignment of funding and incentives.

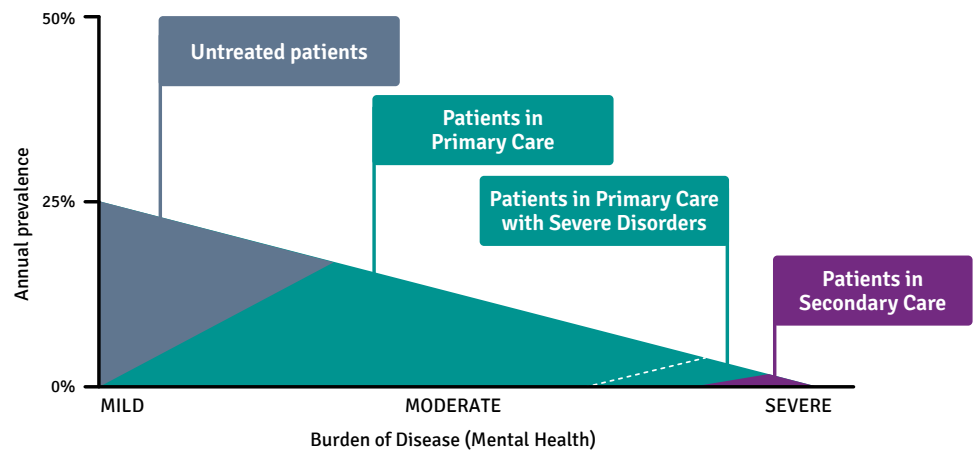
Investment in the current system is skewed towards the provision of high cost and low volume treatment services. A lack of access to lower intensity interventions means that some people are potentially being provided with more treatment than what is required, or are receiving treatment later, by which time they are sicker than they should be. By increasing the focus on early intervention for mild and moderate conditions and aligning treatment and support to the needs of an individual, demand for secondary and tertiary treatment services can be eased and costs associated with preventable hospitalisations reduced.

The need to rebalance and improve the system of care for people with mental health and associated issues has been highlighted in a series of reviews and frameworks. Improving person centred approaches, improving service navigation and integration continues to be emphasised, along with an enhanced role for primary care.

Better Choices, Better Lives: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Better Choices, Better Lives) points to a picture of lack of access and underutilisation of primary care services by Western Australians experiencing mental health issues.

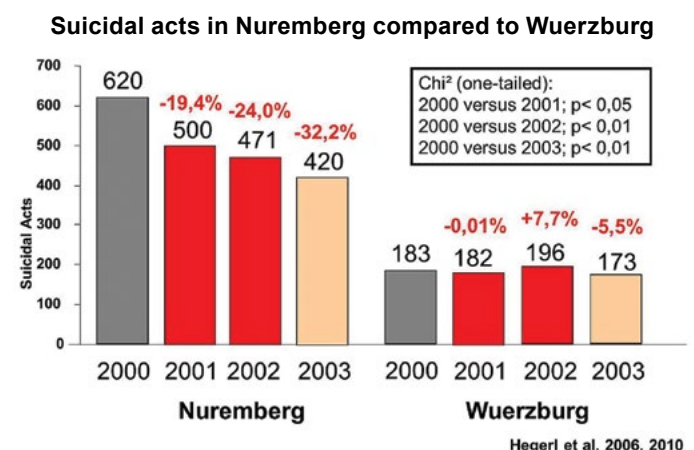
Problematic alcohol and drug use is not always visible and can be the underlying cause of a wide range of health and social harms. The National Ice Taskforce report highlights the need to develop the primary care workforce and provide greater access to care through GPs.

Service integration is more than partnerships, collaboration and co-location. It needs to occur both around the person at the local level, and be reinforced across the system.



The World Health Organisation defines integration as “The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.”

The value and importance of ensuring an integrated system is demonstrated by the European Alliance Against Depression’s Multilevel Approach to the Prevention of Suicidal Behavior in Nuremberg.



This community based, four level intervention includes education of primary care physicians, a professional public relations campaign, training for community facilitators and interventions with affected persons and high risk groups. While each intervention has inherent value, real impact on the reduction of suicides only comes with integration of all four components.

Stepped Care

Customising interventions to meet individual needs is the basis of a stepped care approach. The underlying principles are that the least burden, in terms of personal inconvenience and cost, is placed on the individual (and the system) to achieve a beneficial outcome, and the level of intensity is adjusted in response to feedback. In other words, the individual receives no more and no less than is required.

Multiple levels and services can exist within a stepped care approach. They do not operate in silos or as one directional steps. Rather, they provide a spectrum of service interventions encompassing both treatment and support.

Rather than having to start at the lowest, least intensive intervention to progress to the next 'step', individuals enter the system at any stage and have their service level aligned to their requirements.

Stepped care enables development of a partnership between primary care practitioners and the people they treat. Integral to success are appropriate links with community support services and professionals through both collaborative and shared care models of care.

Low intensity interventions

A key service platform within a stepped care approach is provision of low intensity interventions. Premised on the principle of early intervention, support and self-management, they emphasise skill development, are short-term and highly focused. Interventions can be offered in a variety of formats (e.g. individual, group, telephone and web-based services, face-to-face, and combinations of modalities). They offer an efficient, high quality service that people can access easily and directly, with or without needing a referral.

Telephone and eHealth

Online and telehealth services can offer an alternative, and an adjunct, to face-to-face care that can increase access, decrease wait times and reduce inequity for those in regional areas. Evidence indicates services are popular and effective, particularly for high prevalence mild to moderate mental health disorders and can help to reduce relapse through sustained engagement. Intervention quality can be controlled and services can be adapted to meet the needs of various population groups.



Whole Person, Whole Place, One System

The WAPHA Way

The design of an integrated systems approach for primary mental health care is underpinned by the following:

- A focus on person centred care involving GPs and support services in partnership with the people they care for;
- Local by design and by default - Developing place based and virtual pathways for comprehensive care; enabling flexibility in design and delivery to meet local community needs and resources;
- GP led care is the norm – supporting primary care to respond to the whole person;
- Creating more accessible and timely services through simplifying access and entry;
- Improving the continuum of care for people as they enter and navigate between systems;
- Targeting low intensity psychological interventions to support people with, or at risk of, mild to moderate mental illness (Including problematic alcohol and drug use);
- Bridging the gaps in the provision of services for people in under-serviced and hard to reach populations;
- Supporting shared care systems for people with severe and complex mental illness who are being managed in primary care;
- Finding a better balance between meeting needs and available resources;
- Community engagement and involvement beyond healthcare settings is essential;
- Solutions are framed by collective impact and applied in a real world setting;
- Success is measured by place-based, not program-based, outcomes;
- Systems approach to enhancing public value – not managing by exception.

Whole Person Care

Person centred care is when decisions about the way health care is designed and delivered puts the needs and interests of the person receiving the care first.

Despite the increasing prevalence of multiple morbidities, system fragmentation and access barriers continue to result in problems being treated in isolation. It is well recognised that mental health outcomes are impacted by a variety of characteristics and life factors including chronic physical illness and alcohol and drug use.

Services need to be built around what people need rather than deliver 'programs'. Effecting change is underpinned by the need for sustained effort from the broadest range of health, social and civic services with a commitment to focus on meeting the needs of people at its core.



Transforming Primary Mental Health Care

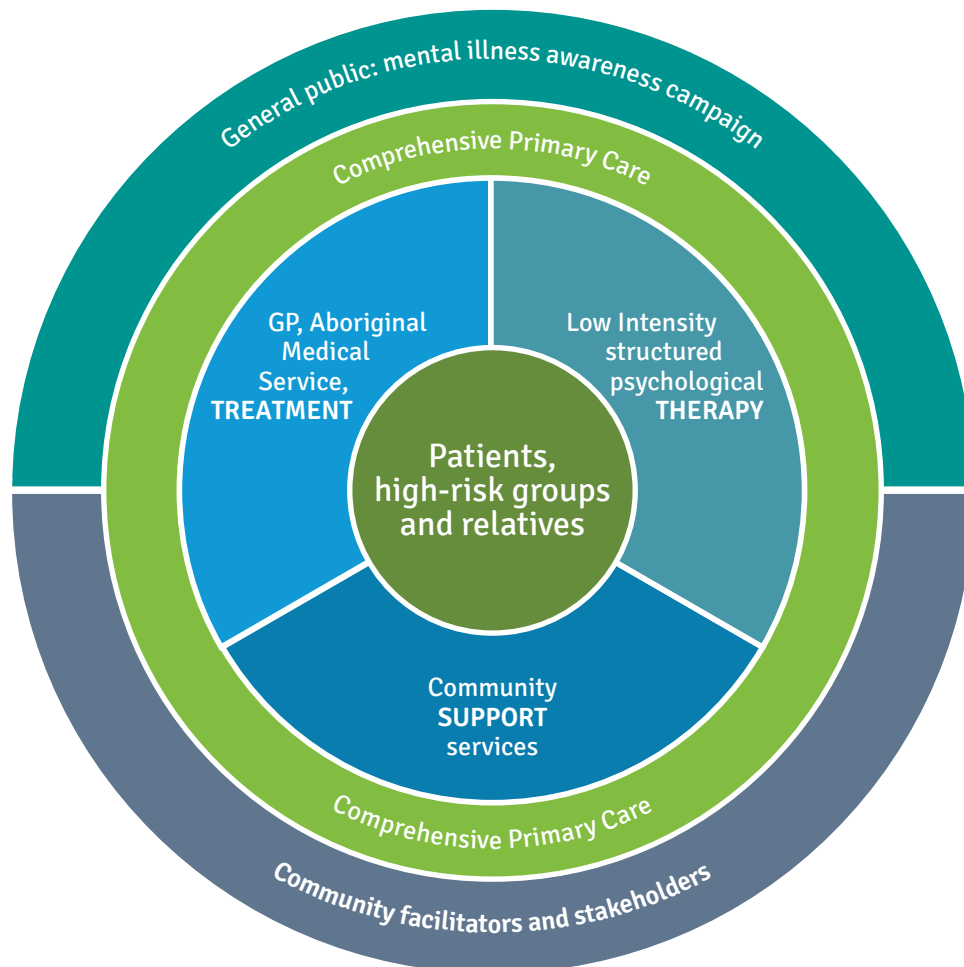
WAPHA is working at varying levels across the WA health landscape with a long-term and sustainable focus on improving access, maintaining quality and facilitating integration.

Most mental health issues are seen and dealt with by GPs, clinicians or other health professionals either because the person has identified symptoms themselves or because conditions are recognised as present alongside physical symptoms and chronic conditions. The most common in general practice are panic and other anxiety syndromes; major depression; and problematic alcohol and drug use.

Research shows that in most cases primary care practitioners who are able to recognise these conditions, independent of the reason for presentation, can provide effective treatment without the need to involve or refer to specialist services. In addition,

where a diagnosable mental health problem is co-morbid with common chronic physical disorders (such as diabetes, and circulatory and respiratory conditions), treating the co-morbid mental disorder (irrespective of its acuity) reduces preventable hospitalisations for the primary physical conditions. Hospitalisation rates for these so called ambulatory care sensitive conditions can vary greatly across WA regions, including within metropolitan Perth.

The model is not about changing the way primary care works. It is about enhancing care, adding value to existing services and providing a structure to make it easier to put people at the centre. Adoption of this model will assist GPs to better manage existing clients, respond effectively to patient flow (including day to day variation in volume and complexity) and potentially reduce the need to refer to specialist treatment services.



The Model

Integrated Primary Mental Health Care – Stepped Care

The model is built around the three core key components:

- 1. Integrated care management** - Support for primary care practitioners through provision of care management and coordination of services which includes systematic feedback using standard, well understood, measures of progress and improvement.
- 2. Low intensity telephone and eHealth** - Central state-wide intake and assessment entry-point for low intensity structured psychological therapies. Regulated and universal access, with the capability to offer higher intensity support where this is not readily accessible.
- 3. Community supports services** – localised, holistic, wrap around services to support the care continuum.

All three components need to exist, although individuals may not need to access each one.

Key aspects

Supporting GPs and other primary care clinicians to recognise and respond to common mental health conditions

Most people who either present with anxiety and depression, or whose underlying anxiety and depression are identified by a GP, will not need further intervention if the GP is equipped to recognise and respond in a way that is recognised to be helpful.

There are essentially three components of care. Treatment, therapy and community support. Intervention may involve initiating somatic treatment such as antidepressant medication, providing guidance or self-directed care materials, referring individuals to community support services as well as listening, demonstrating positive regard, engaging the person's own strengths, respecting self-generated solutions.

Through relevant partnerships, WAPHA will undertake to build the capacity and confidence of primary care practitioners to recognise and respond to common mental health conditions. For a proportion of people

however, it is recognised that this level of care is not enough.

Significantly expanding access to evidence based psychological therapy

GPs and other appropriately credentialed primary care clinicians will be able to refer their patients to a central state-wide entry-point for low intensity structured psychological therapies which will be delivered primarily (but not exclusively) by telephone.

The centralised service will be predicated on a stepped care approach (least burden, self-correcting) and will include planned entry from GPs. The aim of this method of delivery is to achieve parity of access across the state by increasing the numbers of people who will be able to access evidence based support easily.

The service will include a therapeutic intake and assessment process, designed to improve, up front, the matching of intervention with individual needs. Through this service, people can be linked to structured psychological therapies and telehealth resources for either face to face or ear to ear support, community support services and other evidence based short term therapeutic interventions delivered by appropriately trained and supervised staff.

Referral through community support services and self-referral is not precluded. However the extent of available intervention and services will be limited in the first instance.

Inherent in development and delivery of this service will be local capacity building to ensure sustainability in provision of low intensity interventions. The platform will also be underpinned by development of the Commonwealth Government's Digital Gateway. (Refer to the Federal Government's *A new blueprint for mental health services*).

Increasing support through integrated care management

Primary care practitioners will have access to a care management function for people who need a level of extra help in order to have their care needs met. It is anticipated that this would comprise around 20% of people with a mental health problem already seen by GPs. Care management does not preclude the use of structured psychological therapies. The continued involvement by GPs in care plans is required in order to link people to secondary services where necessary.

The Model (Cont'd)

The integrated care “manager” will monitor progress, measure improvement or intervention outcomes using standardised and well understood measures, including patient reported outcomes, provide treatment decision and medication management support, “troubleshoot” problems prior to medical appointments, liaise with GPs, the secondary system, the community support system and the person themselves. This function will provide more time for quality assessments, retain the integrity of primary health care and reduce the shift of resources downstream.

Care coordination will initially be tied to interested practises and align with those interested in delivery of Comprehensive Primary Care (Refer to WAPHA’s *Comprehensive Primary Care* booklet). Care coordination will be telephone based, allowing people to access the service irrespective of local resourcing. Practices with existing care management arrangements will not be excluded on this basis and will be able to refer to the telephone based service should they wish.

Increasing access to community support

Community support will be local and provide support to people who self-refer or who are referred by GPs. Services will range from short term low intensity work groups, one-off interventions and referral sessions to high intensity psychological therapies for on-going mental health conditions.

Community support services are considered to be both informal and formal community structures, people and institutions. The primary function is to assist with wrap around support, support movement along the care continuum, and facilitate ongoing and sustained engagement and support.

Improving support for shared care

For the group of people who have major mental health disorders (schizophrenia; major mood disorders etc.), shared care between GP and psychiatrist can be very successful but only if the GP is supported. Shared care requires a committed psychiatrist and a care coordination function. Most shared care is provided by a small number of GPs who commit a very significant amount of time and effort into these arrangements, in most cases with state-based public mental health services. For the model to expand as it should will require an aligned strategic approach involving strong engagement between general practice and the state health system. The benefits for patient care are significant and WAPHA is committed to developing a much improved model of shared care across the state.

Elements of The Model

The fundamental elements to the whole model are:

- Most people need and will receive brief interventions and/or low intensity services;
- This can be delivered at entry point and through community support services;
- The care management functions make the integration of the steps possible;
- The model does not work without the community support element.

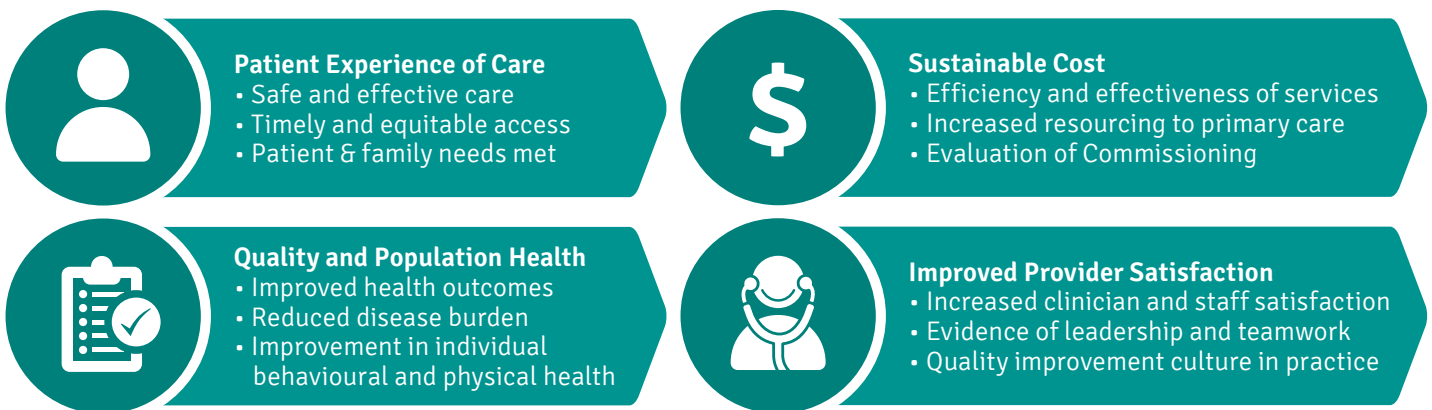
Measuring Outcomes

Measuring outcomes from WAPHA's investment in the development of an Integrated Primary Mental Health Care framework is an important consideration.

This needs to consider the impact of both the WA PHNs' traditional approach to supporting general practice and also their responsibility as PHNs being broader than general practice alone.

WAPHA has adopted the Quadruple Aim Framework founded in the work by the Institute for Healthcare Improvement, Triple Aim, and complemented by Bodenheimer and Sinsky's revised approach: *From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider*.

Defining the Quadruple Aim:



What Can We Do?

WAPHA is committed to investment in quality cost effective services that are sustainable and lead to better health outcomes for people. We need to change the way we work to accommodate demand. This means creating a more responsive system to meet the needs of those with mild to moderate problems and those who may otherwise not seek treatment until their needs are high.

WAPHA and the WA PHNs will develop and enhance the integrated framework within the WA context as well as continue engagement with PHNs across Australia.

Continued collaboration with key stakeholders and the community services sector is essential. WAPHA and the PHNs will facilitate opportunities for co-design and local application in response to identified priority areas of need.



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