phn
EASTERN MELBOURNE
An Australian Government Initiative

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EMPHN Low Intensity Co-Design Workshop

Low Intensity Psychological Services Forum

Service design and identification of hard to reach target groups

WORKSHOP OBJECTIVES:

Share what PHN is and what services it provides

Draw upon the experience from health professionals to seek input to identifying hard to reach groups for the sector (session 1)

Design innovative low intensity mental health services for the future state of ATAPS and Better Access Models

HARD TO REACH GROUPS

In groups the participants were asked who they thought are the hard to reach target groups in the mental health sector?

THE QUESTIONS WERE:

Who is the Target group	How to engage/ access this target group	Important stakeholders/ organisations that relate to this target group	Barriers to engaging this target group

RESISTANT TO SERVICE

Stakeholder Group	Resistance to service
Ideas to access/engage this group	Support child care / day service. If people call - someone calls. Peer support or other non traditional clinical options. Option to access services without mental health plan. Drop in. Creativity and calm groups. More informal. Varied modalities i.e. using technology.
Stakeholder/ organisations who are well connected to this group	Community. Employees / workplaces. Sporting clubs. Churches. Organisations with focus on increasing knowledge of mental health.
Barriers to engage this group	Provider driven model of care. Pathologizing. Child care using and sharing. Language.
Other important considerations	We need a broader department of interventions, strength based model from access through, not deficit model.

PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

Stakeholder Group	People from culturally and linguistically diverse backgrounds.
Ideas to access/engage this group	Collaboration between services - culturally appropriate responses - training to create a culturally safe environment. De-stigmatising clinicians and counselling. Different referral strategies or simpler forms. Referred by other workers not just GPs. Access to interpreters. Privacy information. Right geography shared between services.
Stakeholder/ organisations who are well connected to this group	Migrant info centre. Asylum seeker services AIMES, Red Cross. Life without barriers. AIMES humanitarian program. EOL classes. English other language. Swinburne AIMES. Community leaders and associations. GPs. Schools and early childhood services.
Barriers to engage this group	Low English language proficiency and low literacy in their own language. Shame - cultural both Australia and how mental health viewed in own culture. Language doesn't define mental illness well. Fear, lack of trust. How intensity is not well serviced. Literature not in simple language. Lack of awareness of ATAPS. Lack of centralised locations.
Other important considerations	Central intake isn't where the client or assessor is located also adds one more barrier.

PEOPLE IN REMOTE LOCATIONS

Stakeholder Group	People in remote locations
Ideas to access/engage this group	Drop in service. Increase provision in remote areas and growth. Engage elders in community. Increase GP education and programs available. Helplines. Decrease paperwork required. Increase and diversify people who can refer.
Stakeholder/ organisations who are well connected to this group	Community agencies. Mother and child health. Developers. Schools. Community members and elders.
Barriers to engage this group	Lack of infrastructure. Shame. Lack of IT skills, access, so cannot have referrals. Cultural sensitivity. Isolation. Pathologizing. Language.
Other important considerations	Sometimes low prevalence needs a model broader than just the clinical. Needs to be part of community and building connections. Come visit.

MOTHERS WITH YOUNG CHILDREN (WITHOUT CHILDCARE).

Stakeholder Group	Mothers with young children (without childcare).
Ideas to access/engage this group	Outreach at MCHN centres. Pre-natal education / support. Hospital - D/C information re support services. Mothers will generally put children first - if children accessing services, this is an opportunity to engage.
Stakeholder/ organisations who are well connected to this group	MCHN enhanced. Allied health services e.g. speech path. Families / friends.
Barriers to engage this group	Isolated, stuck at home, no family / friends. Expectations - life should be good! Should be happy, should know what to do. Focus on child - unaware of own issues. Childcare.
Other important considerations	Value of communities. Peers - great support, potentially mothers groups. Aged care - older adults to support new parents. Often looking after own parents as well.

PEOPLE EFFECTED BY POSTTRAUMATIC STRESS DISORDER

Stakeholder Group	Post Traumatic Stress Disorder
Ideas to access/engage this group	Early intervention at time of symptoms. Health promotion, GP education. Cultural shift re coping with stress. Workplace programs e.g. mental health first aid training. Online connections.
Stakeholder/ organisations who are well connected to this group	Foundation house. Employment specific services e.g. police counselling. Vietnam veterans. Emergency services. Refugee services. Families.
Barriers to engage this group	Identification of issue - keeping symptoms to themselves, affects such a broad range of people - no OSFA solution. Longer pathway to support.
Other important considerations	Mental health promotion. Mental health training in undergraduate studies.

CARERS DIAGNOSED WITH MENTAL ILLNESS

Stakeholder Group	Carers diagnosed with mental illness.
Ideas to access/engage this group	Via the service providers for the caree. GP / service provider to check on carers well being.
Stakeholder/ organisations who are well connected to this group	PIR, GPs, CATT, families.
Barriers to engage this group	Carers don't know that they are carers. Full time caring role = little time for themselves. Personal experience of the system - don't want to engage themselves, worried about outcome if diagnosed. Social isolation / no supports. Expectation to cope.
Other important considerations	Co-dependency. Discrepancies between familial and the work required as a carer.

PEOPLE WHO HAVE DIFFICULTY IDENTIFYING MENTAL HEALTH SYMPTOMS

Stakeholder Group	People poor at understanding symptoms.
Ideas to access/engage this group	GP "wellbeing" clinic monthly. Neighbourhood houses programs. Community health services. Education re symptoms. Peer supports.
Stakeholder/ organisations who are well connected to this group	GPs, family members. If without above - community health.
Barriers to engage this group	Fear and hiding symptoms of treatment / diagnosis. Labelling / stigma. Lose job e.g. police, ADF, fire brigade.
Other important considerations	Need to move far away from symptom focus to identify needs / goals.

PEOPLE WHO WILL NOT ENGAGE WITH PHONE INTAKE

Stakeholder Group	Phone intake
Ideas to access/engage this group	Re-introduce duty worker. Online access e.g. live chat. Supported referrals (a real person - liaison role).
Stakeholder/ organisations who are well connected to this group	Community health services. Similar backgrounds. GPs. Families.
Barriers to engage this group	Language, culture, fear, lack of personal connection. 75% of what we hear is what we see.GP - 6 minute consult. Multiple steps, get lost in the process.
Other important considerations	Wrap around care e.g. person with diabetes, psychotic illness. General health checks.

HOMELESS / PEOPLE AT RISK OF HOMELESSNESS

Stakeholder Group	Homeless / people at risk of homelessness
Ideas to access/engage this group	Co-location of MH practitioners in courts, social housing. Laundry vans for homeless. Providing showering facilities. Work with parents to educate re risk of homelessness.
Stakeholder/ organisations who are well connected to this group	RDNS Homeless persons program rangers (council). Police. Reconnect schools. CYMHS / early psychosis teams.
Barriers to engage this group	Learned helplessness. Parental knowledge re issues driving homelessness.
Other important considerations	Positive psychology (Martin Seligman). People who know them have given up. Early education / intervention.

YOUNG CARERS (CHILDREN WHO CARE FOR PARENTS WITH A MENTAL ILLNESS)

Stakeholder Group	Young carers (children who care for parents with a mental illness)
Ideas to access/engage this group	Better knowledge between child and adult services. School refusal services. Technology, online services. Continue to develop success of existing initiatives. Reduce mental illness stigma. Training for child protection and other family support services.
Stakeholder/ organisations who are well connected to this group	SKIPS, Carers Vic, COPMI, community health. Commonwealth funded resource, support program for children whose parents have a mental illness needs to continue to be funded.
Barriers to engage this group	If parents don't seek treatment. If they are not identified when parents present. If the identification is not followed up with support.
Other important considerations	Victorian government FAPMI program extended in last budget to all clinical services should also have a presence in community services - it should be funded for the direct work.

MALES (INCLUDING YOUNG MALES)

Stakeholder Group	Males (including young males)
Ideas to access/engage this group	TAFE / alternative education. Awareness raising campaign services. Early innovation. Websites and magazines present in waiting rooms. SMS. Mensline Australia. Access through D&A services and DV services / forensic services.
Stakeholder/ organisations who are well connected to this group	Employment services, child protection, relationship, family services, DV services, Men's shed, Mensline Australia, some universities.
Barriers to engage this group	Country services. Attitudes. Male therapist access. Fear to present. "I'll be alright". Stereotypes. Type of services / flexible. Stigma. Denial. After hours support. Outreach.

ASYLUM SEEKERS

Stakeholder Group	Asylum seekers
Ideas to access/engage this group	Culturally aware community events. Informal community support to build genuine connections.
Stakeholder/ organisations who are well connected to this group	Asylum centre, resource centre, AIMES, churches, Red Cross, CALD leaders.
Barriers to engage this group	Language, finances / funding, cultural barriers, isolation.
Other important considerations	Broad responses - counselling is very culturally restrictive, need to think laterally.

EARLY SCHOOL LEAVERS

Stakeholder Group	Early school leavers
Ideas to access/engage this group	School based programs, resilience, post school options education. Foster relationships. Parental education. Connect sports groups. School welfare officers. Use peers to assist rep.
Stakeholder/ organisations who are well connected to this group	Head space. Centrelink. TAFE. School welfare team. Sporting clubs. Employment services. Headspace. Homeless services.
Barriers to engage this group	Parental consent. Narrow window of opportunity to pathways to support, involve, engage. Multiple steps requiring GP referral. No existing relationships with service providers.
Other important considerations	Preventative. School culture. ATAPS in school. Family unit as a whole.

SINGLE PARENTS

Stakeholder Group	Single parents
Ideas to access/engage this group	Online. Single parent group sessions - play groups, through councils, community services. Centrelink. Community health. GP. Schools. MH services. Child protection. Child care / kinder setting. Maternal child health. Family services. Need childcare facilities, child friendly sessions and outreach.
Stakeholder/ organisations who are well connected to this group	Centrelink. Maternal health services - council. Child protection.
Barriers to engage this group	Child protection. Mental health literacy. Money and poverty. Transport. Young parents. Lack of child care. Lack of after hours support. Need outreach. Might impact family court matters.
Other important considerations	Education in mental health services through the media, about what services are out there (to inform GPs in particular).

STUDENTS WITH NO ACCESS TO MEDICARE

Stakeholder Group	No access to medicare (students)
Ideas to access/engage this group	Secondary referrer (not GP). Different delivery model run by own community. Free services for special circumstances (i.e. no medicare to access services).
Stakeholder/ organisations who are well connected to this group	Universities. Settlement services. Multicultural groups / organisations.
Barriers to engage this group	Language / understanding. Shame / pressure. Cultural differences (counselling = interrogation).
Other important considerations	Multilingual / specialist.

DUAL DIAGNOSIS

Stakeholder Group	Dual diagnosis
Ideas to access/engage this group	ATAPS could offer bridging services during wait for detox e.g. motivational interviewing. 24/7 anonymous / accessible services. Services being confident, equipped to support people or refer warm referrals. Outreach.
Stakeholder/ organisations who are well connected to this group	Turning point 24/7 online and phone services. Community mental health services. Homeless services e.g. Wesley. Drug and alcohol services. Disability services.
Barriers to engage this group	Clients who don't engage. Stigma. Competence in professionals to pick up and treat dual diagnosis, including perception that they are not dual skilled. Waitlists, delays to access. Services who do not have an integrated approach. Trust of services. Barriers created with "I can't help this problem" attitude.
Other important considerations	Workforce that may be competent but not ATAPS eligible. Too many screening tools - unclear of their benefits. Upskill clinicians to deal with dual diagnosis. People need to be adequately resourced to assist in referrals to other services.

ADOLESCENTS

Stakeholder Group	Adolescents
Ideas to access/engage this group	Schools, TAFE, education institutions. Youth groups. Social media - Facebook, twitter, snapchat.
Stakeholder/ organisations who are well connected to this group	Headspace. Schools / uni / TAFE.
Barriers to engage this group	Finance, transport, parental consent, time.

PEOPLE FROM LGBTIQ BACKGROUNDS

Stakeholder Group	LGBTIQ
Ideas to access/engage this group	Community focus. Awareness of further education in schools and universities. Youth services - local government. Social media.
Stakeholder/ organisations who are well connected to this group	Freeza. Local government. Headspace.
Barriers to engage this group	Stigma. Finances. Disengaged from community. Over connected with professional services.

CARERS FOR THOSE WITH MENTAL ILLNESS

Stakeholder Group	Carers for those with mental illness
Ideas to access/engage this group	More respite services. Making services accessible after hours. Raising awareness about the carers role. Educating services about carers and how to support them. Broader community awareness - schools, community, community houses, carer support groups (online access).
Stakeholder/ organisations who are well connected to this group	Wellways. Carers Vic. Migrant information centre - dedicated to carers. Unitingcare. Villa Maria.
Barriers to engage this group	Identifying themselves as carers / or themselves needing support. Stigma of mental illness. Engaging. The person the carer is caring for can be a barrier to the carer accessing services. Time and carer duties restrict freedoms to engage on service.
Other important considerations	Employers being more considerate of carers. Family inclusive / informed treatment.

PEOPLE IMPACTED BY FAMILY VIOLENCE

Stakeholder Group	Family violence
Ideas to access/engage this group	More advertising available services to this group. Embedding knowledge regarding ATAP's referrals in local medical clinics for this group to access. Health promotion in schools to educate children in family violence situations to know where to access services / help etc. Education to emergency services / school staff to notice family violence red flags. Groups (community). Awareness for family violence. Local GP awareness. Maternal child health nurse. Health professionals that visit schools.
Stakeholder/ organisations who are well connected to this group	GP services. Emergency services (Vic police client liaison officers). Schools. Maternal and child health. Community groups (can be ethnic specific group). Family violence services. Refugees.
Barriers to engage this group	Shame. Fear. Lack of information that's CALD appropriate. Unaware of services. Hopelessness. Lack of resources e.g. finance, childcare. Stigma. Tried to engage and I failed, no one could help. Time constraints. Prioritising other areas.
Other important considerations	Is there a need to expand on the ATAP's professional education about prevalence of family violence in the community?

AGED 65+

Stakeholder Group	Aged 65+
Ideas to access/engage this group	Community groups. Family members. Health services. GPs. Centrelink. Pharmacies.
Stakeholder/ organisations who are well connected to this group	Hospitals. Men's shed. Local GPs. HACC. Pharmacists. Neighbourhood houses. My aged care. Community health centre.
Barriers to engage this group	Resistance to counselling. Pride. Loneliness, isolation. Dual diagnosis. Mobility. Generation gap with clinicians. Funding / income. Men difficult to engage. Narrative of formative years.
Other important considerations	Employing older persons to support this community. Could be grandparents / carers and full time carers for grandkids. Aging population. Cultural considerations.

OLDER POPULATION

Stakeholder Group	Older population
Ideas to access/engage this group	Target RACS / SRS / ILU. Community home services having easy referral pathways to mental health. Churches. Hospital discharge planner. Rotary / senior citizen. Database of pensioners. Office of housing
Stakeholder/ organisations who are well connected to this group	HARP.
Barriers to engage this group	Staff not trained in mental health. Inability to share e-health. Pride. Fear. Public aged care cannot access ATAPs. Family violence, elder abuse. Lack of understanding of psychological services.
Other important considerations	Social isolation, lack of use of technology.

PEOPLE AT RISK OF MENTAL HEALTH ISSUES OR WITH UNDIAGNOSED PROBLEMS

Stakeholder Group	Undiagnosed / early intervention
Ideas to access/engage this group	Awareness campaigns to recognise early signs. Culturally relevant. Mental health first aid - schools / organisations with follow up planning or networks.
Stakeholder/ organisations who are well connected to this group	Universal services. Maternal and child health. GPs. School / early childhood services.
Barriers to engage this group	Stigma, cultural understandings, negative previous experiences in help seeking. Assumptions e.g. it's just a stage.
Other important considerations	Limited funding at promotion / prevention end. Difficulties in sharing outcomes - you prevent it you can't see it. Age appropriate.

FAST GROWING COMMUNITIES -NO MENTAL HEALTH INFRASTRUCTURE

Stakeholder Group	Fast growing communities -no mental health infrastructure
Ideas to access/engage this group	Community awareness of mental health. Walking groups / community activities run by mental health organisations e.g. bbq. Council. Training up local providers to support navigation to service.
Stakeholder/ organisations who are well connected to this group	Local council. Local medical practices. Any local community groups. Community leaders. State planner.
Barriers to engage this group	Lack of infrastructure. GPs, community groups. Language / culture. Timing of activities - new estates. Working couples / families. Isolation. Transportation.

ANY PERSON ENGAGING WITH LEGAL ACTION (CHILD PROTECTION ETC.), WORRIED ABOUT IMPLICATIONS OF RECEIVING DIAGNOSIS

Stakeholder Group	Any person engaging with legal action (child protection etc.), implications of receiving diagnosis.
Ideas to access/engage this group	Parenting / education classes. Support groups. Advocacy. Legal aid. Employ targeted staff.
Stakeholder/ organisations who are well connected to this group	DHHS, child protection, foster care services, out of care services, legal services, schools, mental health.
Barriers to engage this group	Mental health diagnosis / stigma. Legal / custody access issues. Co-parenting issues. Statutory care. Conflict of interest. Non engagement.

PEOPLE WHO HAVE EXPERIENCED A TRAUMATIC LIFE EVENT

Stakeholder Group	People who have experienced a traumatic life event
Ideas to access/engage this group	Program collateral / general services promotion using information triggers to address these people. Free access to services. Awareness raising with agencies. No requirement prior to service entry for a diagnosis of anxiety / depression / PTSD.
Stakeholder/ organisations who are well connected to this group	Insurance companies (health, return to work). Victim support. Police and emergency services.
Barriers to engage this group	They may not have a clear understanding of the mental health effects of the trauma. Reluctance to engage with mental health services. General Australian culture of “she’ll be alright”. Stigma.
Other important considerations	Interventions need to focus on goal setting and resilience building. Group therapy options may suit this group also. Different support required at different stages e.g. psychological and first aid in early stages to try and prevent difficulties later e.g. in disaster context.

FAMILIES IN PERSISTENT CARE, CHRONIC FAMILY BREAKDOWN

Stakeholder Group	Families in persistent care, chronic family breakdown
Ideas to access/engage this group	More community education. Secondary consultations with services that may have access to these families. Easier access to services - like one off sessions / single sessions / brief intervention models. Better pathways / communication / network.
Stakeholder/ organisations who are well connected to this group	DHS / Childfirst / Anglicare area mental health. Schools / early childhood services. NGOs in community.
Barriers to engage this group	Carer fatigue. Financial. Lack of support generally. Potential perception that mental health is deprioritised by those affected - they just have bigger problems.
Other important considerations	Length of involvement - not a one size fits all solution.

WOMEN WITH PERINATAL DEPRESSION

Stakeholder Group	Women with perinatal depression
Ideas to access/engage this group	Social / community connections. Structures that support mothers in the early stages. GPs lack of knowledge. Support for partners. Culturally appropriate. After hours appointments. Outreach. Good connections with maternal health care nurses and child health. Childcare. Child friendly facilities. Drop in centre. Walk in group. Baby gym groups. Group work mother and baby. Age appropriate clinicians.
Stakeholder/ organisations who are well connected to this group	GPs. Mother and child health nurses. Midwives. PANDA. Beyond blue. Perinatal and infant through public mental health.
Barriers to engage this group	Shame, stigma, isolation, lack of support, language, clinical. Not accepting diagnosis. Unidentified diagnosis. Family violence. Maternal and child health nurses make referrals.
Other important considerations	Transport. Childcare. Sensitivity by workers. Cultural sensitivity.

FATHERS

Stakeholder Group	Fathers
Ideas to access/engage this group	Outreach. Male Australian culture. After hours. Less formal drop in centres e.g. men's shed. Parenting groups. Dad's playgroups. Resources and literature. National media campaigns.
Stakeholder/ organisations who are well connected to this group	GPs. Child protection. Community health. MCHNs. Community. Playgroups.
Barriers to engage this group	De-stigmatising parenting roles e.g. women have prejudice towards men as parents. Shame. Social expectations. Stereotypes - gender. Police / child protection.
Other important considerations	Cultural stigma.

YOUNG PEOPLE 12-25

Stakeholder Group	Young people 12-25
Ideas to access/engage this group	School based programs. Outreach. Online programs. Coordinated care with services (collaborative practice). More drop in programs. Group programs.
Stakeholder/ organisations who are well connected to this group	Headspace, GPs, CYMHS, youth services (local council etc.), community health, reconnections, create, Berry St and others.
Barriers to engage this group	Stigma, developmental, GPs (sometimes - paperwork). Environment (outreach), clinical model / diagnosis.
Other important considerations	Family inclusive, culturally sensitive, appropriately trained staff, scope for different therapies.

YOUNG PEOPLE 0-12

Stakeholder Group	Young people 0-12
Ideas to access/engage this group	School based care. Kinder / child care. Perinatal services. Outreach. Child protection. Online. Coordinated collaborative care.
Stakeholder/ organisations who are well connected to this group	Child protection. GPs. CYMHS. Childfirst. Family services. Berry St. Maternal child and health nurse. Schools
Barriers to engage this group	Mental health of parents. Transport issues. Child MH trumped by adolescent crisis. Medical model / diagnosis required. Short term treatment for long term issues. Funding cuts / changes. Parental interest. Clinic based services - need outreach. Need to support earlier (kinder).
Other important considerations	Family - couples, family therapy, play therapy. Trained staff. Collaborative work / systems. Group programs.

UNFINISHED

Financial hardship (unemployment)

People impacted by severe climate events

People who can't leave home (agrophobic)

Widows

Long term unemployed

People less able to pay with transport issues

Centrelink (MH services available clients and staff)

Grandparents caring for children

Aboriginal and Torres Strait Islander People

Those impacted by shame/stigma

People with a disability

Forcing people to get a diagnosis for ATAPS etc

People who have self harmed, people concerned about having a diagnosis on their medical record or at risk of suicide


Medicare Benefits Schedule Better
Access

LEAD SITE PILOT FEEDBACK

COMMONWEALTH SPECIFICATIONS SHEET

The Commonwealth have proposed that the low intensity services commissioned by PHNs are cognisant of three broad definitions inherent in low intensity mental health services. These characteristics, outlined in a Department of Health low intensity lead site paper are as follows.

1 Consumer characteristics

1.1 Low intensity services provide evidence based psychological intervention (e.g. cognitive behavioural therapy) to people with, or at risk of, mild mental illness (primarily anxiety and/or depressive disorders), where clinically appropriate.

2 Provider characteristics

2.1 Low intensity mental health services are primarily delivered by individuals with appropriate competencies but who do not meet the requirements for registration, credentialing or recognition as a mental health professional. This may include, for instance, people who have received specific training to deliver CBT, or provisionally registered psychologists completing a postgraduate clinical psychology qualification under supervision from a clinical psychologist.

2.2 Low intensity services are distinct from psychological therapy services for underserviced groups that are delivered by appropriately registered, credentialed and recognised mental health professionals (primarily registered and clinical psychologists, mental health nurses, social workers, occupational therapists and Aboriginal and Torres Strait Islander health workers) within their scope of practice.

3 Service characteristics

3.1 Low intensity services provide an efficient and less costly early intervention alternative to higher cost psychological services available through the Medicare Benefits Schedule (MBS) Better Access initiative or other primary mental health care services funded from the PHN flexible pool.

3.2 The frequency and volume of services is appropriate to meet the needs of people with, or at risk of, mild mental illness, noting that services should be delivered in a time-limited manner, rather than as an ongoing service.

3.3 Low intensity services can be offered in a variety of delivery formats (e.g. individual, group, telephone and web-based, face-to-face, and combinations of modalities).

3.4 These services should not duplicate other services more appropriately provided through the MBS and other national initiatives (e.g. existing Commonwealth funded digital mental health services), or through the PHN (e.g. psychological therapy services) or other organisations, including state and territory government services.

3.5 They provide easily accessible service which may not require a referral from a medical practitioner, noting that it is best practice to involve a medical practitioner in overall health and mental health care.

3.6 Low intensity services are delivered in the context of a stepped care approach, meaning they are not delivered in isolation from other levels of service

SESSION 2: PART A FEEDBACK

The Participants were asked to read the Commonwealth specifications sheet for the Lead Site Pilot project and provide commentary on what components they supported, not supported, the risks and opportunities?

What components do you support and why (they were asked to number their responses.

1.1 Greater scope for different interventions. Potential for preventative work. 2.1 Like appropriate competencies.	2.1 Provider characteristics. Less clogging of system - reduce waitlist / timeframe. Early intervention. More people can access - less stigma associated. You can have groups.	3.1 Support that low intensity should be addressed. 3.2 Agree. 3.3 Agree. Tailor each mode to client needs. 3.4 Agree compatibly. 3.5 Agree. 3.6 Agree.
The low intensity activity works for a proportion of the population that might otherwise not access services. Innovative and supportive.	3.3 Possibilities of different modalities of support e.g. self help, peer groups. Breaks down isolation. Clients do not need to have a mental health plan. Target more of hard to reach groups. Foster creativity and innovation in service models.	2.1 Qualified staff with different experience bio / social workforce. Supervision for the workforce. 2.2 Easier to access / no GP (barrier). 3.3 Flexible delivery model / more accessible - less rigid.
2.1. Support provider characteristics as long as there is support and supervision behind it. An organisation, team provision of service. 1.0 Agree - a provision of low intensity services.	3.3 Online may be able to access multiple clinicians in different modalities. No referral forms (one less barrier). Opens up services for early intervention (not even at the stage of unwellness yet). Preventative.	3.3 Web based / telephone services - access for remote areas.

What components don't you support and why?

2.1 Some concerns over non-registered providers for specific populations. Language not reflected well - "mild mental illness" = diagnosis? Or just symptoms?

3.1 Low cost. Need to invest in it if you want it to work and access more people. 3.3 Need web based to be united, not the parallel.

1.1 Duality assurance. Fidelity, clinical governance, flexibility / adaptable to specific needs of clients. Not registered potentially. Could further disengage some clients. What does the intake process look like? Can anyone refer?

1.1 Evidence based and new / innovative contradiction. 3.2 What if needs to be long term?

2.1 / 2.2 Unqualified staff - ineffective / risky assessment and treatment. 3.1 Low intensity category shouldn't mean cheaper service.

1.1 Should read "likely consumers of low intensity session would be ..." Need more consumer characteristic rather than service characteristic or diagnoses. Very diagnosis driven. Who defines "clinically appropriate" - this will mean that early intervention is missed. 2.1 The way it's written excludes all registered health professionals.

Opportunities/Recommendations

2.1 / 2.2 Good quality early intervention programs by qualified clinicians. 3.3 Possible use of peer support groups / drop ins / group work (facilitated).

Good intake, good questions asked to vet clients properly. Beyond Blue provide good online options.

More universal. Use existing community services staff. Invest in infrastructure that exists. Good links and collaboration between low intensity and high intensity. Support structures that build collaborative partnerships.

Example - Come Visit program - grief line.

Low intensity lead sites is potentially an opportunity to provide and change management for those adjusting to a diagnosis / preparing for diagnosis. Opportunities for specific groups to partner with MH services. Risks require formal and clear measurement.

1.1 Not essential - MHTP. 2.1 We support new access para-professional, workforce type. UKNHS, IAPT evaluation, 80% don't need other services. 88% of self referred go through program so they are getting the right people.

How do we build in evaluations? Early intervention / health promotion. Money to go to services able to demonstrate solid clinical governance. Peer training in schools. Mentoring for service delivery people.

Do you foresee any risks?

De-professionalising the workforce. Cultural and service adaptability. Might not work for all client groups.

Clients going into wrong programs / may not access the supports required. Ability to step up - assessment and how it was done. Gaps / matching client to best appropriate services. Practitioners practicing outside their scope. Training should be clear. Practitioners / student psych should be appropriate for program (skills set and lack of experience).

Are people actually delivery based interventions? 1.1 Are you attracting the genuine client? Could need more support than what is being offered e.g. psychotic goes undetected. 3.6 Who coordinates the services?

Yes. 1.1 Very specific to anxiety and depression. Missing out on early intervention. Self referral. 2.1. If registered professionals are excluded there is no one to clinically supervise.

2.1 Well-meaning / less skilled workforce may not know to escalate up steps (need good clinical governance). Who defines the activity?

Need to ensure that service is evidence based. Support for service providers is given.

3.3 Be careful with excess symptoms on web based and telephone services.

3.3 Dis-incentive for full services? Doctors - lack of insight? Lack if incentive for mental health patients to qualify.

LEAD SITE PILOT INNOVATION

SESSION 2: PART B INNOVATIVE MODEL

Participants were initially asked to think about and design potential models for innovative low intensity health provision.

THE GUDING QUESTIONS WERE:

What would it look like to you?	How would you roll it out?	Who would it benefit?

Each of the seven groups designed and received feedback on their proposal.

1 INTAKE (QUALIFIED MENTAL HEALTH INTAKE)

Self / phone / online. GP. Higher intensity required. Use evidence based screening tool that is adaptable to needs of client.

Community services
Face to face. List of trained providers in different areas. Phone. Web (immediate / self / therapist guided). Do not want to duplicate existing services. Length. Depends on needs. 3-6 session cap.

Higher level required
Conclude care. Review point. Would need to be a change of provider / clinician if stepping in. Done by supervisor of trained provider. Trained providers - non qualified. Want to give client a positive experience.

2 EMPHN

Lead agency, funded to coordinate all of agency collaboration / networking / partnerships. Use existing organisations / service providers who run wellbeing groups / programs to run this in collaboration with EMPHN for low intensity interventions, so consumers can be offered a suit of tailored groups / programs to needs.

Invest in collaborating to occur between service providers by either appointing a lead agency to create this structure or for EMPHN to lead this and create this collaborative structure.

Limit red tape by having one contract to deliver these services. National and universal programs. Stepped care - continuity of care with one clinician / care coordinator. Therapeutic relationship is core.

Referrals go to EMPHN intake. Referrals can be made by health professionals, self, family / carers. Referrals have to be voluntary and clients have choice of which service that they want. Services offered can be, but not limited to: parenting groups (young mums and dads), mentoring, general peer support groups, psycho-ed groups, creative therapy group.

How this model fits with other organisations - CYMHS, child protection. Marketing strategy - need to develop, what is low intensity. Map of services in area - what they offer.

3 PERSON, PHONE, TECHNOLOGY, FLOATING, WELLNESS.

Virtual central point, brief intervention mentoring line. Local, connect, networks, collaboration, leverage off existing, to determine portfolio roles based on community needs, aged, CALD etc. Major theme immediacy. Culturally supportive social models. Partnership, multi model, flexible. Screening skills. Wellness. Co-contribution. Students. Beyond Blue. Clinical councils, community advisory. CHS.

4 THE WELLNESS MODEL

Creating a story. Measured evaluation. Shared resources. Change management. Free! Peer support. Self referral. Variety of delivery modality, online, phone, skype etc. Plain language, no more mental health language. Focus on wellbeing and being happy. The parameters of a wellness based approach to low intensity mental health care. Maybe even non-medical. Addressing barriers. Clinician lead, group, peer, individual response.

5 WEB BASED ENTRY

Personal control in support options - preferences, strengths based, wellness focus. eMental Health partnerships - access to CBT / MHFA psychoeducation. Role of groups in access - non clinical. Support for step up - high prevalence disorders. Responsiveness. Partnerships. Role of trainees (psychology, OT, SW, MH nursing) low cost, well supported. Moderated online opportunities - chat, phone. Role of PHN in selling benefits of low intensity.

6 PREVENTATIVE MODEL

Creating change. Big picture. Not band aid effect. Link with universities. Signs of risk, look at research. Resilience - schools, including home-schools, alternative education. PHN and uni do own research evaluation. Clinical supervisor, health students, parents, teachers, welfare staff, GP, police. Mentoring resilience groups, psycho education. Substances, mindfulness, eating disorders, MSSI, physical / mental health. Community services. Seccolleges - school focus. Direct employ supervisor. GP included in psycho-education.

7 WHAT / HOW / FEATURES

What
Access.

How
Self referral. Online / phone / face-to-face. Drop in. Fast access. Free. Apps. 24/7.

Features
No MHTP. Validated screening tool. Anonymous. Based on client's goals.

What
Workforce appropriate competencies not necessarily psych (clinical), could be non health professional.

How
Trained and competent. Ongoing supervision. Clinical governance. Integrated and collaborative. Evidence based. Holistic process.

Features
Evidence based on IAPT new access workforce. Includes peer support workers that support the model. Includes champions / ambassadors from the local community.

What
Model

How
Sits within a stepped care model. Short term program with follow-up. Broad range of modalities. Flexible. Client centred.

Features
Holistic setting for wrap around care. Focused on client goals rather than program criteria directing intervention.

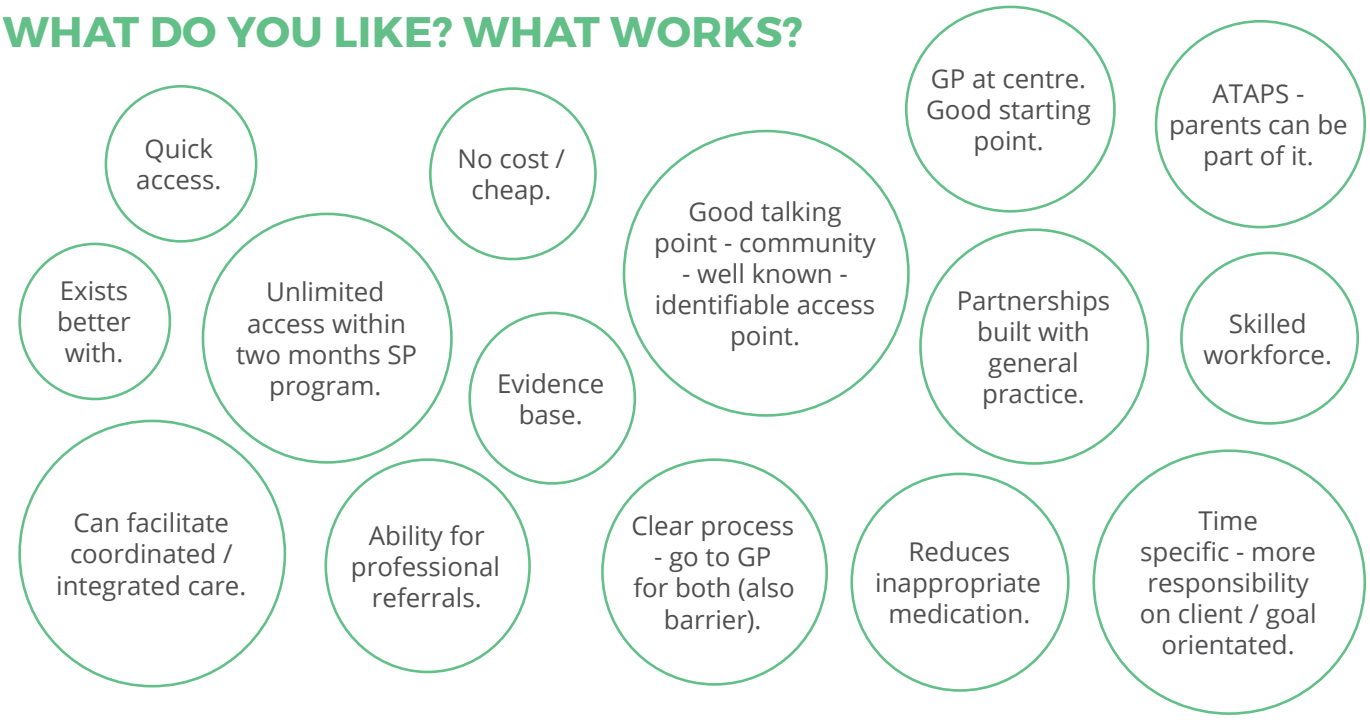
What would it look like?
Self referral. No MHTP needed but do need a plan of care / client goals. Validated screening tools (simple to use). Anonymous. Faster access to trained MH professionals. Online access 24/7, apps and SMS. Works where the client is at (client does not have to have goals yet). Drop in. Outreach and inreach. Includes a peer support worker (to assist engagement) - good to target for training to become the MH professional. Fee free. Based on UK's IAPT model and their evidence base. Includes MH champions to act as role models and have connections to the community. Ready made workforce with people trained as councillors or training in psychology (not just clinical psychology, including provisional psychologists). Well linked to other services but overseen by a peak body. Delivered at community health meetings, not so much at GP clinics. Holistic focus, integrated services. Broad range of therapeutic modalities to focus on what the client needs (rather than the program criteria directing therapy used). Not necessarily therapy as it includes people at risk.

ATAPS AND BETTER ACCESS

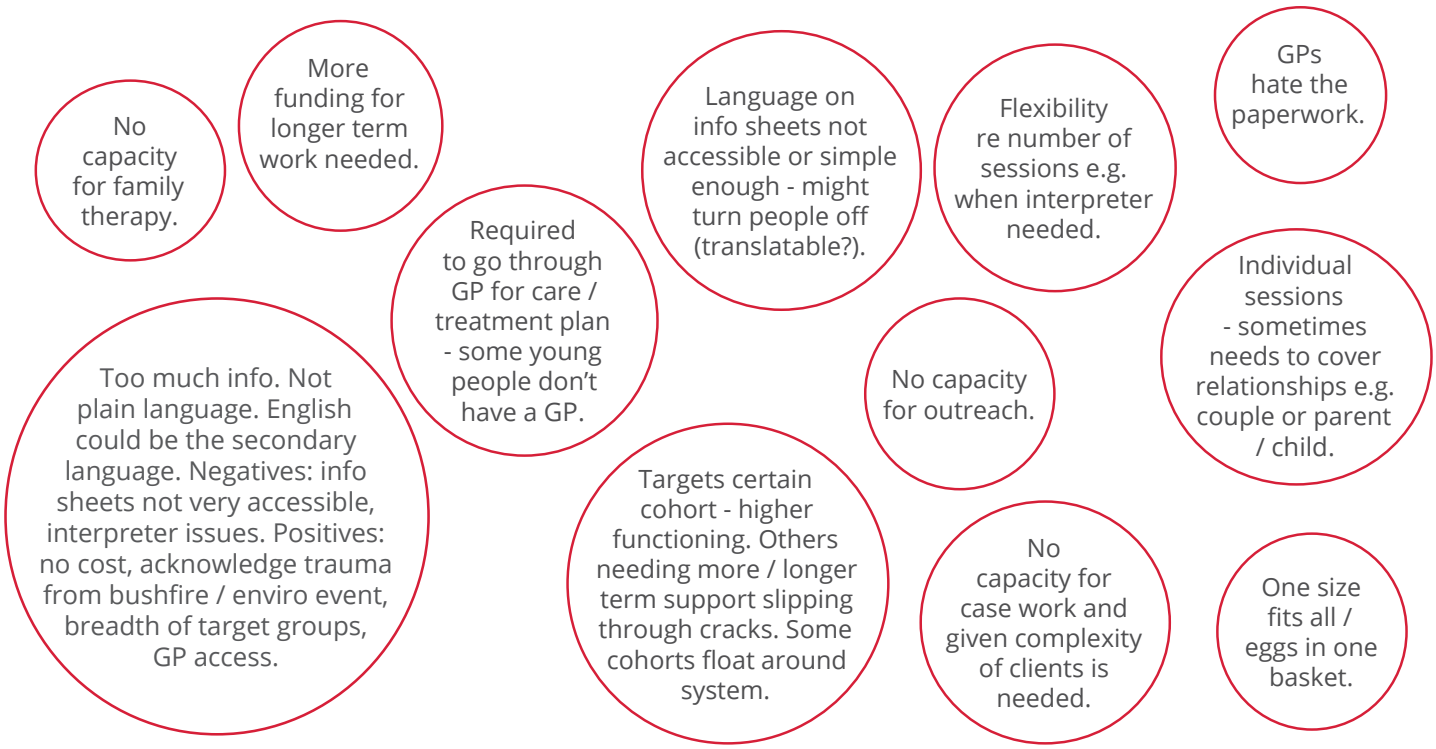
PART A

EMPHN described the current ATAPS and Better Access models to the group and sought feedback on them as they currently stand. As a whole group the participants brainstormed, what do they liked about these models/what works. What they don't like/ What are the gaps.

WHAT DO YOU LIKE? WHAT WORKS?



WHAT DON'T YOU LIKE? WHAT DOESN'T WORK?



ATAPS AND BETTER ACCESS

PART B

Participants were asked to design a replacement for the ATAPS and Better Access models. They were asked what would their dream model look like. For example the next iteration of ATAPS/Better Access? (in groups of 7)

1

SOLUTION

Flexible sessions - groups, family therapy, couple. Increased modality service delivery. Address diversity in spectrum - awareness, treatment. Continuity of care - post treatment. Flexibility in choice of therapist. Mental health social worker. Client outcome vs earning potential (are there conflicts of interest?). Outcomes measure for referral.

2

REFERRALS

GP, direct to psychologists (don't need diagnosis), schools etc. (welfare services coordinator, Assistant principal, triage through PHN - SC and PS).

STEPPED CARE

Mild - 6 session. Moderate - 12 sessions and more as dependant on clinical need. Minimum paperwork. High needs - psychology then evaluation for change to mental health nurse incentive program. e.g. for trauma - not capped at 2 years. Longer term. Suicide prevention - 2 months.

THERAPEUTIC TYPES - FLEXIBLE.

Couples, family, child-focused, parent work, individual, outreach - exposure, school refusal, agoraphobia and transport access. Care therapeutic coordinators - funded (attend school meetings etc.). Increased telephone support sessions. Managing cancellations. Marketing and knowledge. Community based setting, wrap around care. Simplify language.

3

INDIVIDUALISED APPROACH

GP referral. Money for non direct service delivery. Checklist - presenting issues, interpreter, joint session (family, couple, child/parent), family history of mental health, community visits, level of risk, prior used services, cultural issues, co-morbidities, substances.

4

TARGET GROUPS

Broad and non restrictive.

a) Intake Referrals from GPs and other community referrers. Perhaps GP e-submission of forms rather than fax. Translated or simpler intake forms.

b) Sessions Flexible, place based sessions with flexible times. Ability to extend the appointment as needed. Bilingual psychologists or project workers with welfare experience to assist psychologists.

c) Outcomes and discharge Self assessment - more sessions available if needed.

5

EDUCATE GENERAL POPULATION ABOUT SERVICES - EASY REFERRAL MODEL

Referral - GP or clinically endorsed referrer - Headspace or school psychoanalysis etc. Simplify referral paperwork required. Review paperwork required. Simplify referral form. Still need mental health treatment plan. Clinician completes report after sessions 6 and sends to GP. GP simply signs off the report and faxes it to intake team.Community based setting, wrap around care. Simplify language.

6

FLEXIBILITY MODEL

1) Flexibility about MHTP requirement, especially children. 2) More flexibility re GP review with more sessions possible. 3) ATAPs needs pathway to case managed services where people can be wrapped around for emerging related problems and complex cases. 4) Should be able to see familiar partners without separate referral. 5) Intake options - great if direct. 6) Compatible IT systems - single entry of data, reduced admin burden. 7) Reduced admin for GPs. 8) Open up range of professional able to provide ATAPs services.

7

SESSION 3 - ATAPS NEXT MODEL

Extending into families / couples or expanding referrer options as well. Reduce the paperwork - online or phone referral. Involve client in referral process. Model of care for BPD / emerging BPD to train up network (like Spectrum does with clinical MHS's), implement across whole health network. Based on clinical criteria diagnosis a certain amount of funding is allocated to feedback to GP involvement - still important like coordinating care. Exceptional circumstances and funding. To be responsive to low intensity work as preventive strategy to longer term problems (number of sessions required for preventing). Responsive referral for youth / timely.

phn
EASTERN MELBOURNE

An Australian Government Initiative

Summary report prepared by MosaicLab

mosaic LAB

www.mosaiclab.com.au

PLEASE NOTE: While every effort has been made to transcribe participants comments accurately a small number have not been included in this summary due to the legibility of the content. Please contact Keith Greaves at Keith@mosaiclab.com.au for any suggested additions.