

Primary Health Networks – Eastern Melbourne,
South Eastern Melbourne and North Western Melbourne

Getting it right: National Psychosocial Support Measure Co-design Forum

Conversation Tracker

18 September 2018

Context

About the workshop

The three Primary Health Networks (PHNs) for Eastern Melbourne, South Eastern Melbourne and North Western Melbourne have agreed to work collaboratively to develop and commission consistent approaches for psychosocial support services across their regions. Their collaborations will be guided by the National Psychosocial Support Measure Bilateral Agreement established between the Commonwealth and Victorian governments.

The purpose of the workshop was to provide an opportunity for stakeholders to collaboratively explore the components of the NPS, share knowledge around key elements, identify potential gaps in service delivery and confirm key principles for successful program design.

Purpose of this document

The purpose of this document is to capture a synthesised summary of the conversations and activities that took place during the co-design workshop held on 4 September 2018.

Please note that this document does not capture the conversation verbatim, rather it presents a snapshot of key discussion points and activities and is intended to allow the audience to gain insights into the information generated on the day.

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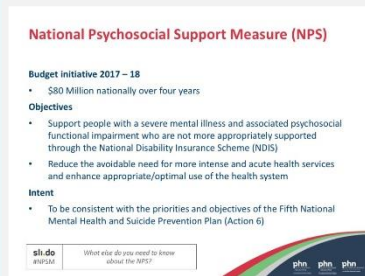
Background presentations

Background and context presentations

Three PHN representatives and Lisa Brophy, of University of Melbourne, provided presentations to set the tone, background and inspiration for the day's workshop activities. Participants were encouraged to use the online application *Slido* to pose questions and comments during the presentations.

Presenter 1 - Anne Lyon

Executive Director, Mental Health and Alcohol and Other Drugs (AOD)
Eastern Melbourne PHN



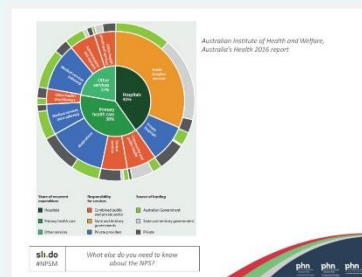
Opening the day, Anne explained the background and purpose of the NPS. She encouraged people to be creative throughout the workshop activities and during her presentations she provided details of:

- The Commonwealth and State Bilateral Agreement's objectives
- Funding agreements for the NPS
- The targeted consumer of the NPS
- The Mental Health Australia Project.

For more information refer to Appendix A for detailed presentation slides.

Presenter 2 - Jag Dhaliwal

Executive Director, Service Development and Reform
North Western Melbourne PHN



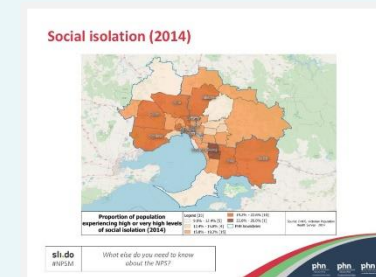
Jag spoke about how the mental health consumer experiences the system.

He encouraged people to think of the whole health system, not just one aspect such as hospitals. He outlined aspirations for changes to the system to help strengthen the stepped care model in primary mental health care clinical service delivery.

For more information refer to Appendix B for detailed presentation slides.

Presenter 3 – Chris Wood

General Manager, System Outcomes
South Eastern Melbourne PHN



Chris spoke about his team's work in understanding the NPS cohort and their contexts. Presenting statistics developed around psychosocial mental health and social inclusion, he painted a picture of the current NPS cohort's needs across the state.

Highlighted statistics included:

- Psychological distress
- Mental health related hospitalisations
- Unemployment
- Homelessness
- Social isolation
- Relative need

For more information refer to Appendix C for detailed presentation slides.

Background and context information

In addition to what was shared at the workshop, the PHNs have received guidance material with the following information:

Purpose of the National Psychosocial Support (NPS) Measure

The purpose of the NPS measure is to provide psychosocial support services to assist people with severe mental illness resulting in reduced psychosocial functional capacity who are not eligible for assistance through the National Disability Insurance Scheme (NDIS).

Who is the NPS for?

The NPS initiative is for the group for whom clinical care is not enough to help them build capacity for daily living and who would benefit from specialised psychosocial support at particular points in time. There are no age restrictions on this initiative.

Focus of the NPS

- Building capacity and connectedness at times when it is most needed
- Shorter-term psychosocial support
- Regional, stepped care approach
- Flexible and integrated service delivery
- Link to clinical services and care coordination

Key areas of activity

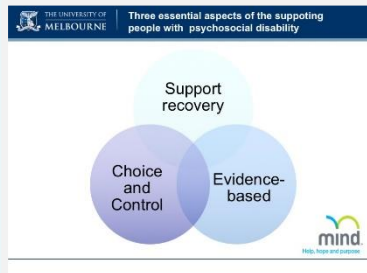
These could focus on building capacity and stability in one or more of the following areas:

- Social skills and friendships
- Family connections
- Managing daily living needs
- Financial management and budgeting
- Finding and maintaining a home
- Vocational skills and goals, including volunteering
- Educational and training goals
- Maintaining physical wellbeing, including exercise
- Managing drug and alcohol addictions, including tobacco
- Building broader life skills including confidence and resilience

Background and context presentations (cont.)

Presenter 4 – Dr Lisa Brophy

Senior Research Fellow
University of Melbourne



Lisa delved into the current evidence base for psychosocial support approaches and explained emerging areas of research knowledge. Her presentation highlighted:

- Terminology used to describe and understand psychosocial impairments
- The impacts of disability on life domains
- The three essential aspects for supporting people which are support recovery, choice and control, evidence based. Through discussions which had evolved that morning of the workshop, Lisa noted that she saw the need for the addition of a fourth circle - cultural safety.

- A large barrier is the up-take of support for people with psychosocial disabilities
- Information on what people said they need, and what current and emerging supports are either being implemented or developed.

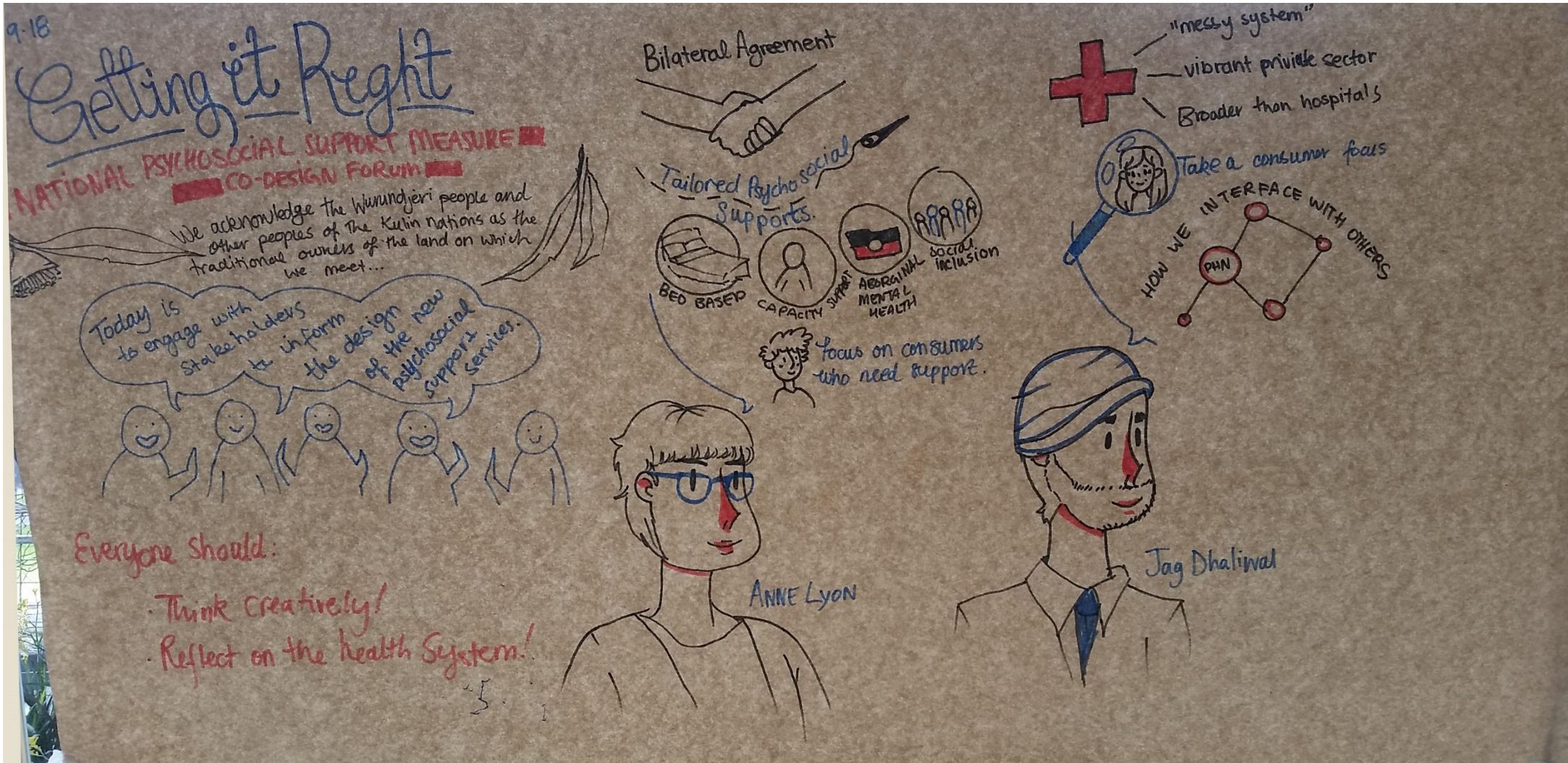
“Codesign and coproduction are the keys to the future of psychosocial support. Uptake is critical. You can have the best supports in the world but if there is no uptake then it’s all for nothing.”

For more information refer to Appendix D for detailed presentation slides.



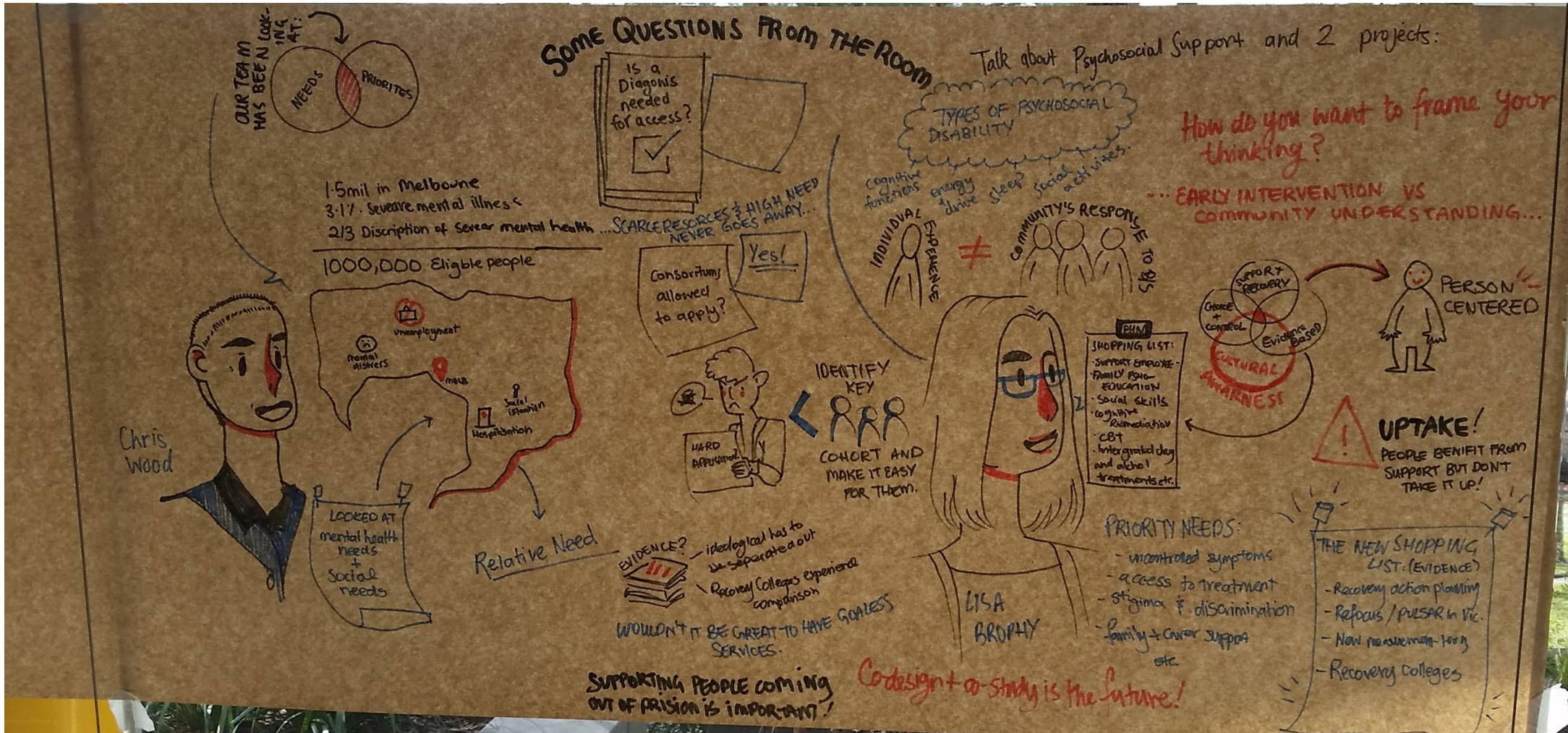
Presentations Livestream

Livescribing of the presentations was undertaken by Dayna Hayman from ThinkPlace.



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Livescribing of the presentations was undertaken by Dayna Hayman from ThinkPlace.



Questions for presenters

Slido questions answered during the session

At the conclusion of the presentations, 4 questions were posed to the presenters for immediate feedback. These included:

Question for Lisa Brophy:

Can you explain more about the recovery hubs?

A: “There is no formal evidence but a lot of talk of ‘it would be great to have more drop ins.’ It’s almost ideological. There’s this idea that we don’t want to foster dependence.

What I’ve found with the work I did with the Melbourne recovery college is people did compare their experience with the recovery college as being hard to adjust to but in the end works better than drop ins. Wouldn’t it be great if we had services without goals?

Question for Lisa Brophy:

Any thoughts about incarceration? It’s the ultimate social exclusion which is not only an outcome of poor mental health and exclusion but exacerbates?

A: “Recovery colleges are extending into prisons. One of the things is that supporting people on release is incredibly important. The death rate of people within one week of release is extraordinary. Within a year people have often had a terrible time. It’s about accidents, emergencies, the cost to communities is high.

This is a really strong need area so preparing people for release and providing release services is incredibly important.”

Question for PHNs:

Will flexible funding be included in the NPS?

A: “The design elements and modelling will establish whether this will be a part of the NPS.”

Question for PHNs:

What do you mean by ‘in the system, already’?

A: “The DHHS contribution to the NPS, as referenced in the bilateral agreement, is already ‘in the system’ across a range of services that the state is funding. We know, from a Commonwealth perspective, PIR will cease June 2019. The Continuity of Support (CoS) program comes on to replace PIR, as well as PHaMs and D2DL, if consumers in these programs do not move to the NDIS. The NPS, though, will seek to address the needs of other consumers who are not able to access the NDIS. Therefore, NPS and CoS are designed to address the emerging gap in supports for those who are not eligible for the NDIS.”

Slido questions during PHN presentations

During the three PHN representatives' presentations, participants used Slido, an online platform, to ask questions. While some key questions were answered in the room, the others were recorded for answers to be provided here in this document.

Q: Is a diagnosis necessary for people to access this service? Will the system support people without psych background but obvious severe concerns into supports?

A: We do not envisage that the NPS will have diagnostic criteria, in line with the NDIS. However, there may be a need to clarify a diagnosis. For the second part of the question, an individual with significant needs may have those needs addressed by other sectors. If the person has not previously engaged with or required mental health services (they are then unlikely to be eligible for the NPS).

Q: How are the State and PHNs collaborating in their work in psychosocial support?

A: The State and PHNs will continue to liaise on how the new NPS measure is designed and rolled out, to ensure there are appropriate linkages, integration of services, and no duplications.

Q: What's our best understanding at the moment of who will not qualify for NDIS despite diagnosis with a severe, ongoing mental illness?

A: Our PIR programs in North and East Melbourne are providing a good indication, currently showing that approximately 15% of PIR participants that have applied for the NDIS have been determined as ineligible by the NDIA. PHaMs services are currently indicating that a significant number of consumers are not being accepted into the NDIS. We will request more detail on the eligibility trends as we get closer to the CoS period post-July 2019.

Q: If the money is already in the system what existing programs will be ceasing?

A: DHHS is to provide greater clarity, but note that the NPS funding is new money for PHNs to commission services.

Q: Are consortiums welcome to apply? Are you expecting the NPS to be the same across 3 PHN's?

A: Consortiums will be able to apply. While it is too early to say, the three PHNs have a goal of achieving consistency in the NPS design and delivery.

Q: What do you mean by "in the system" already? If it's already in services then what influence do we have over service design?

A: DHHS is to provide greater clarity. However, NPS funding is new money for PHNs to commission services. We are seeking feedback for its service design.

Slido questions during PHN presentations (cont.)

Q: Will the consumer criteria for the NPS be as ridiculously hard as the NDIS to access?

A: Clearly, we do not want this to be the case. The NPS needs a flexible approach, considering the ongoing assessment of a consumer's needs, meaning not all the answers will be known 'up front'. The NPS needs to reach local people and be responsive to local needs. The NPS can be designed to provide targeted responses to psychosocial needs and so will not require the 'life-long' commitment and insurance, actuarial approaches of the NDIS.

Q: How does this NPS fit in with the new Homelessness and Rough Sleepers model/funding?

A: The needs assessment being conducted, together with service design elements, will address how this issue intersects with the NPS—given that homelessness consumers may be a priority cohort for the NPS.

Q: Can we have a clear description of the State funded supports outside of NDIS that were mentioned please?

A: DHHS to provide greater clarity.

Q: Where and when will the funding come from for consumers that are not eligible for the NPS? Will there be funding for early intervention programs?

A: The PHNs' Stepped Care services may provide this support (funding) or clinical services and/or other PHN programs. The PHNs do not yet have guidelines from the Commonwealth on the Continuity of Support program (once PIR, PHaMs and D2DL programs cease).

Q: Will flexible funding/brokerage be included in funding packages?

A: The NPS design principles and model will need to explore this.

Q: What shape will NPS funding take? Name? Design? Who is tendering?

A: The NPS design process aims to work with our stakeholders to address these questions.

Slido questions during PHN presentations (cont.)

Q: Should we start to design a service without knowing how many hours we can provide services to clients?

A: The NPS design process needs to address this question.

Q: Is NPS happening elsewhere? What's working?

A: Thirty-one (31) PHNs across the country will roll out the NPS in early 2019.

Q: Why is it called National?

A: All PHNs nationally are rolling out the NPS during 2019.

Q: How will services engage and collaborate with family/ friends/carers?

A: It is part of the NPS design process to link with family, friends and carers.

Q: What we are talking about here already exists MHCSS offer these services.

A: We can't replicate MHCSS, but we can re-focus on key needs.

Q: Is this a crisis service? It appears to be a service for people that may be unwell/disengaged?

A: The NPS is not intended to be a crisis service but, rather, to provide short-term psychosocial supports.

Slido questions during PHN presentations (cont.)

Q: Some current clients of PIR, D2DL and PHaMs are ineligible for NDIS. Current clients are not eligible for NPS. What happens to people in this gap?

A: The Continuity of Support (CoS) program, to be implemented in mid-2019, is intended to address the ongoing needs of PIR, D2DL and PHaMs consumers--who do not transition to the NDIS--when these programs cease.

Q: Can the NPS be provided to clients in State funded long term care facilities (ie CCUs)?

A: No, the focus of the NPS is on the provision of shorter-term psychosocial supports for those in the community who have been determined to not be eligible for the NDIS. People who have spent significant periods of time in long-term care facilities are very likely to be eligible for NDIS supports if transitioning to the community. If during their transition to community they are deemed ineligible for the NDIS, then they would potentially qualify for NPS.

Q: Our clinicians and peers at our clinical tertiary MH service recommend day programs and hubs. What is the evidence for reintroducing this kind of support?

A: We know that NPS funding is not adequate for day programs. NPS funding and brokerage could support psychosocial and capacity building activities in group settings in community centres. Professor Lisa Brophy highlighted the effectiveness of recovery colleges, and such activities could conceivably be accessed and resourced through NPS packages/brokerage.

Q: How will the NPS support consumers who are parents that are eligible?

A: Building design flexibility into the NPS can allow for other services, supporting families/parents, to be engaged.

Q: Will one organisation/consortium be commissioned by all 3 PHNs, or will each PHN commission their own local service from a consistent base developed by the 3 PHNs?

A: This is yet to be determined. Further details about the commissioning of NPS will be available over the coming months.

Q: I am concerned about people who live in remote areas and the financial cost of providing a service to them.

A: The local PHN response needs to address the entire catchment, with potentially a case-by-case response to people in remote areas.

Slido questions during PHN presentations (cont.)

Q: Are NPS services going to be integrated with health services?

A: Yes, as far as possible.

Q: I am concerned that the focus of the service states that NPS isn't about providing ongoing support. How do we support the people who need longer term support?

A: In theory, the NDIS provides life-long supports. NPS will take a recovery and person-centred approach, depending on need.

Q: How will NPS be staffed? 24/7, weekends? Include outreach and crisis? Will it be dynamic to respond to more people in more times of need rather than being stagnant?

A: The NPS is not a crisis program, but these questions need to be addressed in the NPS design process.

Q: Should we consider digital tools as a way of implementing cost effective evidence based psychosocial interventions?

A: Yes, absolutely, and our PHN Stepped Care services are developing new approaches.

Comment: If you want innovation then you need to find difference in agencies providing this service. More away from the usual players!

Q: Thinking about value for money, \$6 million per year could probably fund 15 peer led short term crisis respite houses. Why couldn't this be an option?

A: This is an NPS design idea which can be addressed as part of the design process.

Slido questions during PHN presentations (cont.)

Q: Thinking about co-design and co-production are you including the voices of children and young carers?

A: Yes, we intend to do this through the appropriate organisations (e.g., Tandem, COPMI).

Q: What is being considered for children with severe mental illness under NPS?

A: This is an NPS design issue to be addressed.

Q: How can SCM projects best tailor the service model in this period of flux between transition to NDIS and NPS, now and in the post-PIR and pre-CoS year (2019/20)?

A: Stepped Care services are being involved in current consumer referrals to appropriate support services, identifying consumer needs locally and how they can be met.

Q: Why are we calling this a measure? Measure suggests we are assessing and not providing psychosocial care?

A: The word 'measure' comes from the budget process and policy. An appropriate 'name' for the NPS services is important, so that these services are understood by consumers, families and carers and the wider community. Nationally and regionally, there is merit in every area describing the service in a consistent manner so as not to confuse the sector.

Q: Would anyone like to address the causes of psychosocial impairments/deficiencies/needs? A good clinician not only treats, but understands the cause of illness.

A: We hope that the psychosocial support work will be delivered in partnership with the Stepped Care provisions with a focus on effective, clinical and therapeutic treatment.

Comment: Maybe as it is such a small amount of money it might make more sense to add an outreach component to the stepped care programs.

Response: This is an NPS design issue to be addressed. It will be important to ensure good alignment with clinical mental health services, including mental health stepped care.

Slido questions during PHN presentations (cont.)

Q: Given the small amounts of funding involved, would a healthcare home style funding arrangement work better? Applying funding on a level of need to an existing team?

A: We will look into this further by consulting with PHN coordinators of healthcare home services pilots. NPS services should be delivered flexibly in coordination with other healthcare initiatives.

Q: How about a phone support line (like DirectLine) for clinicians, clients, family and others to provide concrete tips for place-based social inclusion activities?

A: Determining digital resources, as part of the NPS design, is necessary.

Q: Can we think about using NPS to fund some things that haven't been tried before? Perhaps cordon off \$1 million to trial new approaches to invest in change?

A: This is an NPS design issue which could be considered. Recent ILC projects may provide ideas and/or directions.

Slido questions posed during Lisa Brophy's presentation

These are the questions posed via Slido during Lisa Brophy's presentation.

Q: Do you believe that the NDIS categories of support are well designed to meet the needs of consumers?

A: I would like to hear more from consumers who have accessed the NDIS about this, but I think in general the idea of having core supports (that help with basic needs) and capacity building supports (that are more focused skills development and goals) is a good one. I think it's likely that most people need a good combination of both that may change over time depending on their needs and preferences – and personal goals.

Q: Any thoughts about incarceration? It's the ultimate social exclusion which is not only an outcome of poor mental health and exclusion but exacerbates?

A: People in prison commonly experience disability, especially psychosocial disability, and enabling them to access appropriate care, treatment and support is vital for their wellbeing and is also of benefit to the broader community – with the right post release support from health and disability services this could reduce the high rates of self harm, suicide, injury and premature death among people who are released from prisons – as well as assisting them to gain a better life.

Q: For the figure SHIP n=1,825 . Is that for Victoria?

A: Australia wide

Slido questions posed during Lisa Brophy's presentation (cont.)

Q: Outcome measures. What are the best ways to include user feedback in evaluation and design?

A: I suggest a mixed methods approach. There are a range of outcome measures that include clinical recovery (eg: the K10), personal recovery (eg: QPR), wellbeing and quality of life, as well as recovery orientation of the services measures, experience and satisfaction measures that are likely to be useful. The Living in the Community Questionnaire is another good option.

In a mixed methods approach you would also include interviews, focus groups and provide other opportunities to give people a voice in the research or evaluation. It's also highly valuable to include consumer researchers who can provide a lived experience perspective to enhance the project.

Q: On Peer Support - please explain how they are lowest in evidence hierarchy but highest in pro recovery interventions from emerging evidence?

A: The slide you refer to does not present a hierarchy in the same way that the evidence slide does. It is more about what seems to have the strongest links to being pro recovery and I think peer support – while still in an emerging evidence phase – has strong endorsement from the recovery movement and from consumers

Q: What tools are you suggesting us to use for recovery outcomes?

A: See my answer to the previous question. If you want detail about the measures being used in large projects that include recovery outcomes I suggest looking at the protocol papers that have been published by the PULSAR, CORE and SMART projects:

Shawyer, F., Enticott, J. C., Brophy, L., Bruxner, A., Fossey, E., Inder, B., ... & Edan, V. (2017). The PULSAR Specialist Care protocol: a stepped-wedge cluster randomized control trial of a training intervention for community mental health teams in recovery-oriented practice. *BMC psychiatry*, 17(1), 172.

Palmer, V. J., Chondros, P., Piper, D., Callander, R., Weavell, W., Godbee, K., ... & Furler, J. (2015). The CORE study protocol: a stepped wedge cluster randomised controlled trial to test a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness in the community mental health setting. *BMJ open*, 5(3), e006688.

Thomas, N., Farhall, J., Foley, F., Rossell, S. L., Castle, D., Ladd, E., ... & Frankish, R. (2016). Randomised controlled trial of a digitally assisted low intensity intervention to promote personal recovery in persisting psychosis: SMART-Therapy study protocol. *BMC psychiatry*, 16(1), 312.

Understandings of the term 'psychosocial support'

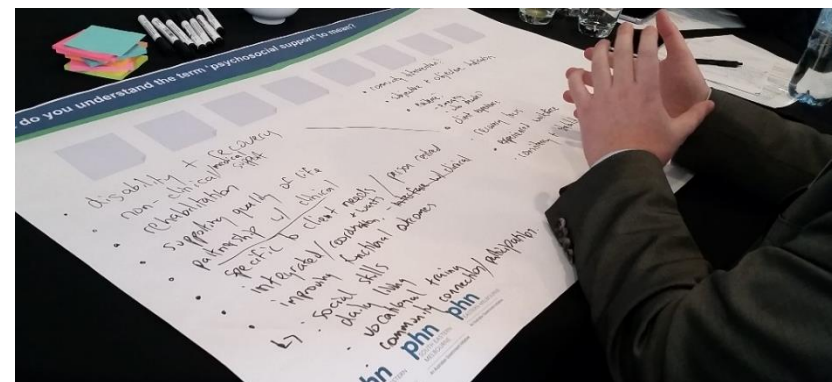
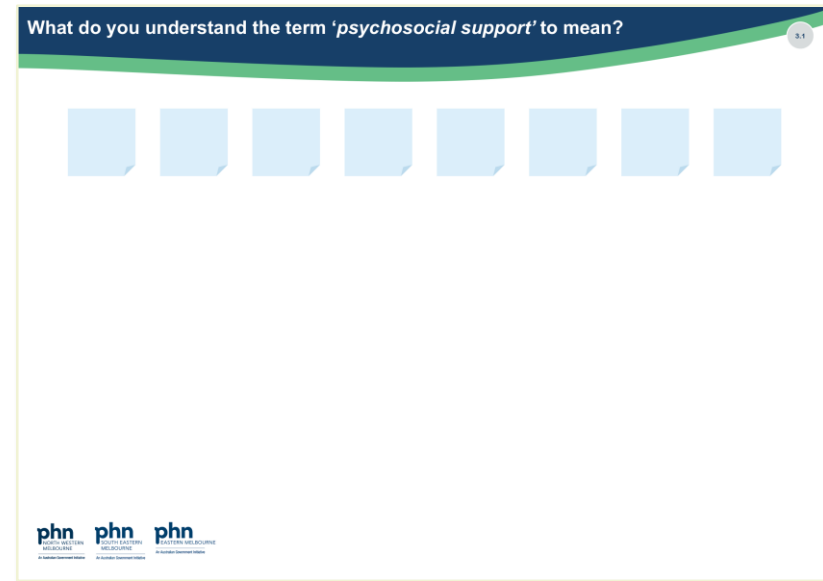
What does 'psychosocial support' mean?

Activity 1: Defining Psychosocial Support

The purpose of this first activity was to engage participants in the NPS domain so that they can understand the scope and boundaries prior to engaging in further workshop activities.

The intended outcome was to establish a shared understanding of the term *psychosocial support* across the participants in the room.

In table groups, participants were provided a template which posed the question "What do you understand the term 'psychosocial support' to mean?". They were encouraged to write their individual responses on post-it notes and then discuss as a table. Tables will then be asked to feedback their top 3 "most critical" responses to the room.



Psychosocial support definitions summary

After considering what *psychosocial support* means, the groups presented back their priority definitions to be:

Support with meaningful connection	Understanding individuals and their context	Support is specific to client needs and is practical	There is an evidence base	Improved functional outcomes	Enable a full and meaningful life for individuals
Social connectedness	24/Hr support available	People are supported in day-to-day living skills and housing	Holistic support over broad areas	Integration, coordination and collaboration across the mental health sector and services	Community based support
Whole of person support	Improved capacity of self and understanding of mental illness	Flexibility with services and support	Have social support comfortably to be a part of society and participate in the community	Understand the importance of family and peers	Getting it right the first time
Community education to have an understanding of mental health	Stretches across all ages	Services are specific, appropriate and are culturally safe	Support is confidential		

Outcomes, workforce and collaboration

A decorative halftone pattern consisting of a grid of small white dots on a dark blue background, located in the bottom right corner of the slide.

Articulating the journey, workforce and collaboration

Activity 2: Developing and selecting personas

Over the afternoon the participants focused on three activities to build an understanding of four different personas. They were:

1. Young person who has been engaged with headspace and has had adolescent risk behaviours
2. A person experiencing homelessness, with AOD issues and no clarity around diagnosis (avoided clinical services until now)
3. Someone who does not want to be an NDIS recipient (for various reasons), however there is concern from the treating team that they have ongoing mental health support needs
4. A person who has been through the NDIS process, believes they have serious mental health needs, but has been told by the NDIA that they are not eligible (ie their application has been rejected).

Personas were used to help focus participants on describing NPS journeys- by articulating the outcomes, needs, interaction touchpoints and services needed for a specific beneficiary.

How many tables described journeys for each persona:

Persona 1

**Total:
2 tables**

Persona 2

**Total:
4 tables**

Persona 3

**Total:
2 tables**

Persona 4

**Total:
2 tables**

Articulating the journey

Activity 3: Understanding needs and services through consumer journey mapping

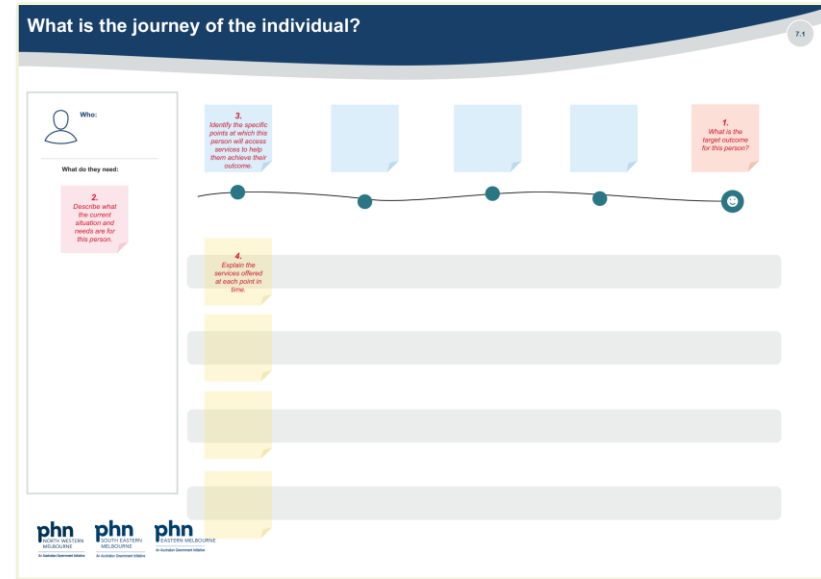
After selecting a persona, participants were provided with a template which asked them to map out the journey of a person who is achieving a good psychosocial outcome from the NPS. Specifically, they were asked to mark-up a journey map to

- Identify the positive outcome for the person
- Describe the current needs for the person
- Identify specific points at which this person will access services to help them achieve their outcome
- Explain which services are being offered at each point in time.

Table groups were encouraged to seek the guidance and input of the consumer/carer representative at their table, to ensure the journey map was a good reflection of people's lived experiences.

Doing this enables the NPS to see the common elements needed across different cohorts to be successful for its consumers based on expert knowledge and lived experiences.

Overleaf, a summary of the information developed across the room is provided.



This template contained step-by-step prompts to describe the journey of a consumer of the NPS.



Personas' needs and outcomes summary

From the personas developed, a series of common needs and outcomes were defined for people accessing the NPS.

Current consumer psychosocial support needs and experiences

Barriers to access include:

- Limited engagement with services
- Lack of awareness of services
- Not connected to clinical supports
- Alcohol and other drugs dependencies
- Social isolation
- Homelessness
- Limited access to affordable housing
- Too many rules and conditions are a barrier to access
- Fragmented relationships
- Exploitation and financial abuse
- Fear of exposure
- Fears regarding parenting and parenting supports

General needs to be met include:

- Employment and financial stability
- Emotional stability
- Education and skill building
- Support for historic trauma
- Regular clinical care and case management



Outcomes to be achieved for consumers using NPS

- Self determination, choice and control
- Knowledge of options and information available
- Stable housing
- Stability in parenting
- Safety
- Engagement with preferred service provider and linked supports
- Connection to community and friends and being socially included
- Empowered to self manage mental health
- Stable mental health
- Secure employment
- Reduced/safer substance use
- Improved physical health
- Increased trust in others
- Stability in family and other relationships
- Ability to do things they enjoy and have fun



Services involved in the journey

Across the journeys, a series of services were identified by participants. These included:

Clinical

[For example: services delivered by GPs, credentialed mental health and AOD clinicians, psychiatrists across primary, secondary and tertiary health]

- Diagnosis clarification
- Medication management
- Case management
- Psychosocial education
- Therapeutic treatment
- AOD services (assessment and treatment)
- Linked with community mental health services
- Prevention planning
- Safety/relapse/discharge planning
- General Practitioners (GPs)
- Psychologist
- Family carer engagement
- Hospital admission/psychiatric wards
- General counselling
- Relationship counselling/family therapy
- Affordability and 1-on-1 support
- Assertive outreach
- Stepped care model (an element of)

Psychosocial

[For example: social skills and friendships, family connections, managing daily living needs, connections to community]

- Secure housing/housing services/housing support
- Social connection
- Employment support
- Meaningful activities
- Identity supports (LGBTIQ, CALD, Aboriginal & Torres Strait Islander)
- Connections to family
- Linked services between physical and mental health needs
- Peer support and peer-based support groups
- Support workers (psychosocial, Centrelink, emotional, etc.)
- Youth groups
- Parenting/family services support
- Recovery colleges
- Marital aid/respice care
- Coaching for self-management
- Health and wellbeing teams
- Package to allow flexible response
- Online support
- TAFE (connections to educational institutions for study)
- Social mentor
- Rest-of-family support in psychosocial education
- Family activities
- Attributes of services: flexibility, consistency, client led/focused, soft entry, early access, no wrong door

Coordinated Care

[For example: linking services]

- Central point of contact
- Support coordination
- GP linkage for Mental Health Care Plan
- Long-term and consistent engagement follow-up
- Key contact to network support

Identifying the workforce

Activity 4: Identifying the required workforce to deliver services

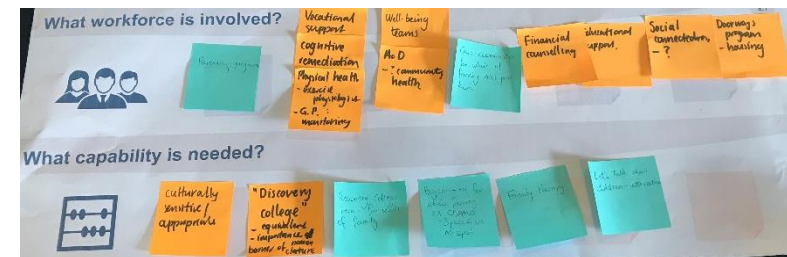
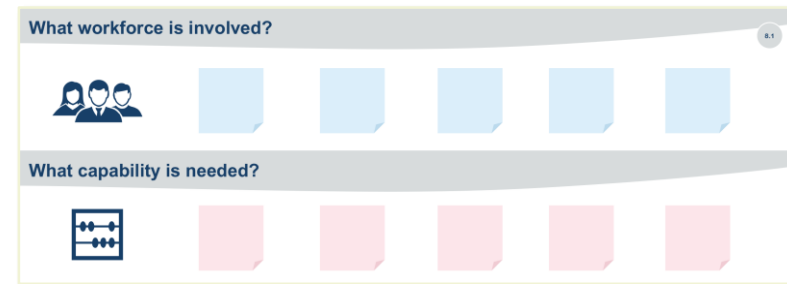
The purpose of this session was to identify the workforce requirements for delivery of the NPS in each consumer's journey. Overleaf, a summary of the information developed across the room is provided.

Participants did this by building on the journey details previously developed. Provided with an additional template to attach to their existing journey template, participants were asked then to consider, for each point in the journey:

- *What workforce is involved in delivery of these services?*
- *What capabilities are offered by the workforce?*

Table groups were encouraged to seek the guidance and input of the consumer/carer representative at their table, to ensure the journey map is a good reflection of people's lived experiences.

Overleaf, a summary of the information developed across the room is provided.



Aligning with the previous templates this one attached to the bottom of the persona's journey. Participants were able to record their details using post-its.

Workforce and capabilities summary

Participants described the workforce and capabilities needed to enable consumer interaction points. Identified across all journeys are the following workforce and capability requirements.

Workforce:

Clinical

- Tertiary mental health qualified staff (nurse, social worker, etc.)
- General Practitioners
- Psychologists
- AOD counsellors
- Clinical staff
- Highly skilled therapist

Psychosocial

- Peer support workers
- Certificate IV trained in disability/community services
- Group program facilitators
- Workers with a high level of skill in understanding recovery and its attributes (strength focused)
- Specialist housing workers
- Family and carers
- Natural supports

Coordinated Care

- Care coordinators

All

- Multi-disciplinary supports

Common Capabilities:

- Flexible, responsive and with good time management skills
- consumer is the driver – with self determination and empowerment
- Transparency
- Consistency
- Diversity of demographics
- Lived experience
- Understands system linkages
- Well trained
- Empathy, passion and enthusiasm for work
- Cultural awareness



Describing collaborations

Activity 5: Describing collaborations to enable service delivery and meet needs

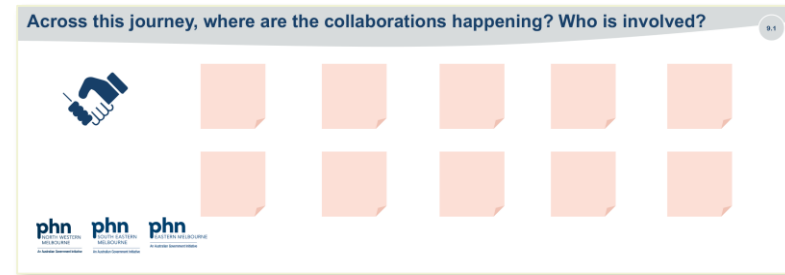
The purpose of this session was to identify the service collaborations required to deliver good outcomes for people accessing services through the NPS. From this, key characteristics (principles) of NPS service delivery were defined.

Building on the journey details previously developed, participants were provided an additional template to attach to their existing journey template. This template asked them to consider, for each point in the journey:

- Where are collaborations happening between service agencies?
- What new and existing services are being offered?
- Who is involved?

At the end of this session, participants were asked to consider their responses to: “What are the key characteristics of collaborative NPS offerings?”. Using Slido, tables reported back all of their key responses.

Overleaf, a summary of the information developed across the room is provided.



Aligning with the previous templates this one attached to the bottom of the person's journey. Participants were able to record their details using post-its.

Characteristics of collaboration

As the day ended participants used Slido to reflect upon the question “what are the key characteristics of collaborative NPS offerings?”. There were three characteristic themes from the responses provided



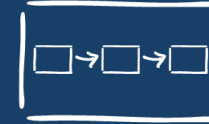
1. Collaboration

The NPS needs to work collaboratively across the sector and services. Collaboration happens between Government and sector levels, clinical and community services, family and individuals. There is no siloed approach.



2. Consumer focused

The consumer is at the centre with an understanding of connection to family and peers. The support is flexible and recovery focused.



3. Simple

The NPS is simple to access and navigate for consumers and workers and provides wrap around services.

There is a fundamental difference between clinical care and psychosocial support. Perhaps there is great value in bridging this gap by educating clinicians, clients and family about the options already available and the importance of social connectedness.

Don't create a new part of the system. Leverage the elements that are working well, ensuring that connections are made to these (rather than replicating them), while ensuring that the voice of peers is prioritised.

A commitment at government and sector levels to not support siloed approaches and to put REAL resources into consumer services that fill the gaps.

Cross sector collaboration. Person centred collaborations with the person's outcomes at the centre. Consumer representation. PHN outcomes and indicators are not necessarily the same as a young person's or consumer's.

Consistent and shared understanding of the model

Characteristics in detail...

Collaboration

Tiered model of support

Shared planning and care. Funding to allow it to happen. Authorising environment, could be supported by PHN

Co - commissioned funding across sectors

Flexible funding - brokerage - for where funds are most needed

Peer workforce that includes individuals with lived experience themselves and are carers of those with MH issues

Common outcome measures and experience measures across sectors

Cross sector collaborative approach

Consistent and shared understanding of the model

Development of staff and continuity in services

Key worker integration and communication

Capacity building service

Wrap around and responsive supports

Respect Accountability

Peer workforce

Combined assessment and care

Collaborations need to be resourced and possibly funded as well

ILC and NPS and PHNs to join in stigma reduction strategies

Person centred collaborations with the person's outcomes at the centre

Cross sector collaboration

Shared care protocol and shared single recovery plan across services

Innovation and new partnerships

Collaboration between clinical and community based services, city councils, local libraries, fitness centres to offer a consistent approach to holistic wellbeing where people get a sense of belonging to peer based activities, finding meaning and purpose within their local community

Setting collaboration as a key part of service design. This means funding staff in a manner that acknowledges partnership work in their time. Potentially include collaborative outcomes as a part of KPIs or expectations.

A commitment at government and sector levels to not support siloed approaches and to put REAL resources into consumer services that fill the gaps

Workforce who are themselves resilient and hopeful- challenging in the context of the ever changing landscape of mental health

Family inclusive wrap around supports (including needs of consumer and families including children)

Culturally responsive, collaborative outcome measures (one person, one plan)-holistic

Characteristics in detail...



Characteristics in detail...



Next steps

A decorative halftone pattern consisting of a grid of small white dots on a dark blue background, located in the bottom right corner of the slide.

Next steps

1

Confirm the principles of NPS service offerings

This can be done through further consultation with key stakeholders, including Department of Health, service providers, representative groups consumers and carers.

The form of this consultation might include surveys, discovery interviews and co-design workshops. Further details will be provided in the near future.

2

Confirm commissioning approach

The PHNs will consider whether to take a collaborative or individual approach to market with a decision to be made October 2018 (indicative).

3

Clarify commissioning requirements

PHNs will clarify the requirements for commissioning the NPS service.

The tender will be released late 2018, with service delivery commencement date in early 2019 (indicative).

For more information, please contact:

“On behalf of my PHN colleagues, thank you to all who participated in the workshop.”

- Jag Dhaliwal

ThinkPlace



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Eastern Melbourne Primary Health Network

Getting it right: National Psychosocial Support Measure Co-design Forum

Appendices

18 September 2018

Appendix A

Presentation from Anne Lyon, Executive Director, Mental Health and Alcohol and Other Drugs (AOD), Eastern Melbourne PHN

Commonwealth/State Bilateral Agreement

- Outlines the Objectives, Outcomes and Activities through an agreed approach to implementation of the National Psychosocial Measure
- Outlines the Commonwealth & State financial contribution
- Funding for this measure will not be used to meet continuity of support obligations to existing clients of mental health programs

Bilateral Agreement

Victoria's contribution – DHHS

- Funds a range of tailored psychosocial supports for people with severe mental illness and associated psychosocial disability, their families and carers
- Funding is already committed and in the “system”
- Key areas for co-contribution:
 - Bed-based residential rehabilitation services
 - Capacity building supports
 - Aboriginal mental health
 - Social inclusion and homelessness initiatives

National Psychosocial Support Measure (NPS)

Budget initiative 2017 – 18

- \$80 Million nationally over four years

Objectives

- Support people with a severe mental illness and associated psychosocial functional impairment who are not more appropriately supported through the National Disability Insurance Scheme (NDIS)
- Reduce the avoidable need for more intense and acute health services and enhance appropriate/optimal use of the health system

Intent

- To be consistent with the priorities and objectives of the Fifth National Mental Health and Suicide Prevention Plan (Action 6)

National Psychosocial Support Measure (NPS)

Consumer population

- People with severe mental illness
- Have an associated level of reduced psychosocial functional capacity
- Are not assisted by the NDIS
- Are not clients of existing community mental health programs including PIR, D2DL and PHaMs programs

Mental Health Australia Project – Update

Optimising Support for Psychosocial Disability

- The technical report on the MHA project has been delivered
- The project management group is considering the advice in the technical report and is focused on shaping clear advice to the NDIA based on the evidence
- The sector looks forward to the findings and how they might inform our future work on the NPS and CoS

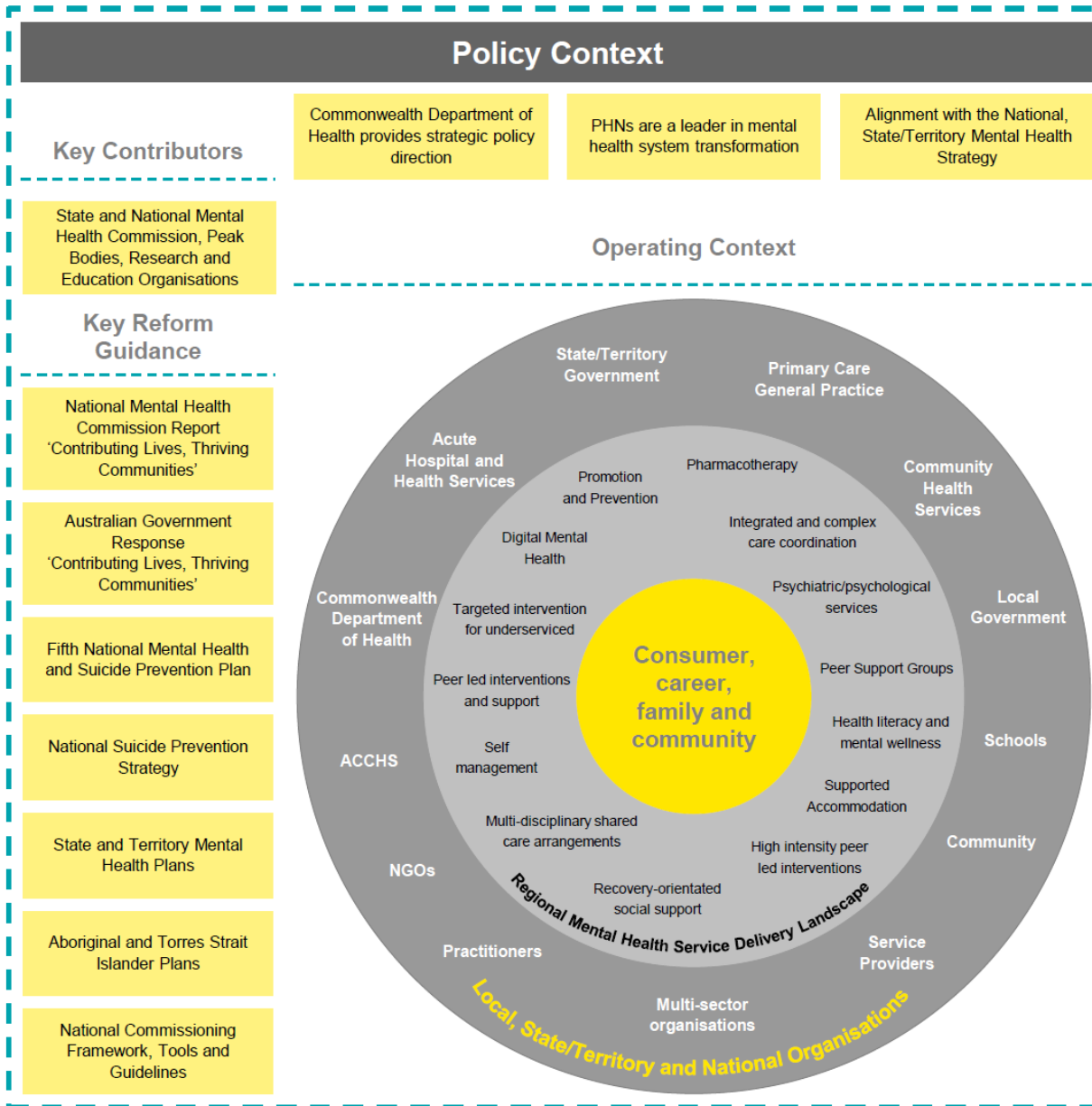
Appendix B

Presentation from Jag Dhaliwal, Executive Director, Service Development and Reform,
North Western Melbourne PHN

Australian Institute of Health and Welfare,
Australia's Health 2016 report



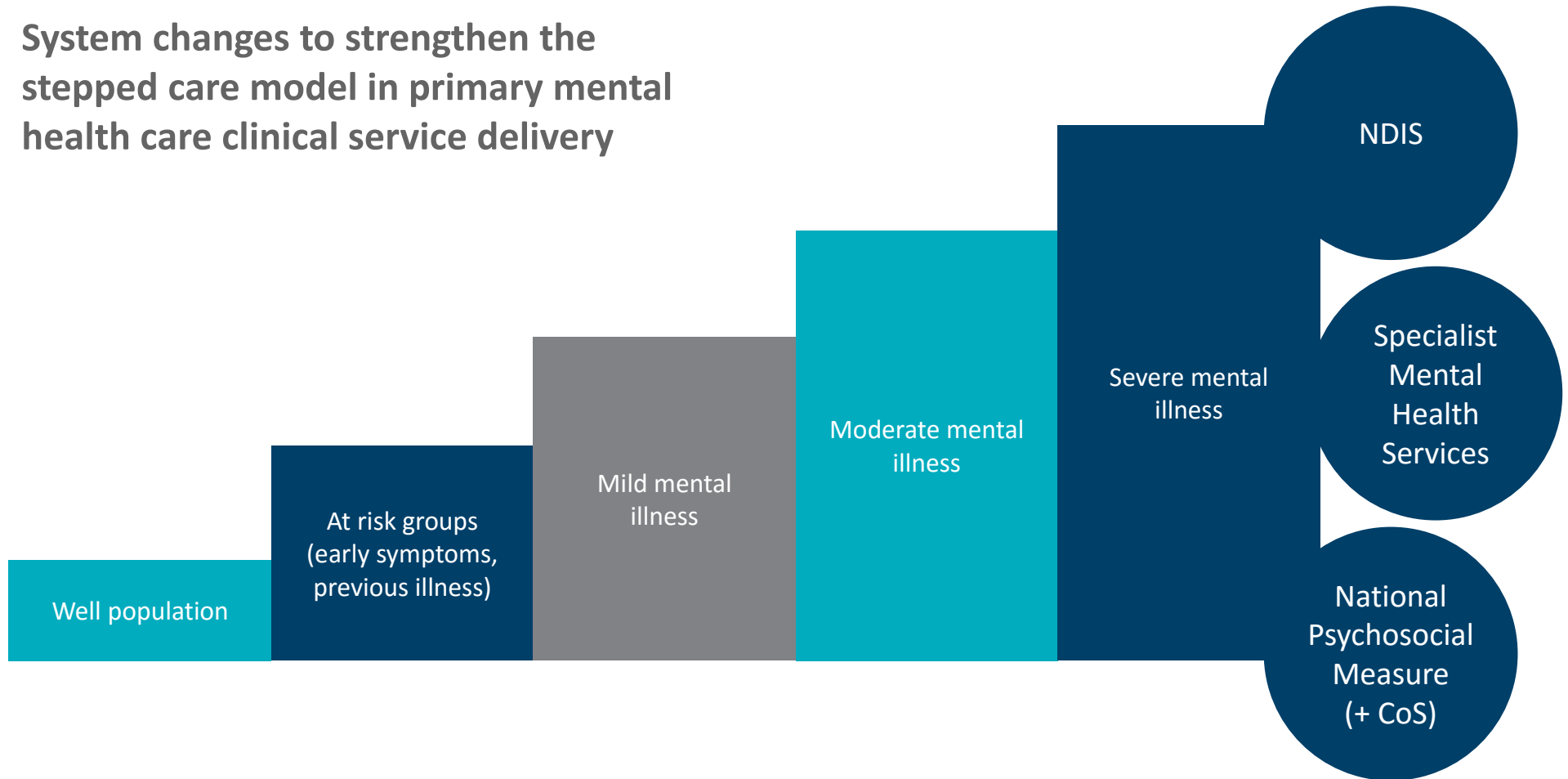
Share of recurrent expenditure	Responsibility for services	Source of funding
■ Hospitals	■ Combined public and private sector	■ Australian Government
■ Primary health care	■ State and territory governments	■ State and territory governments
■ Other services	■ Private providers	■ Private



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PHN Stepped Care

System changes to strengthen the stepped care model in primary mental health care clinical service delivery



Appendix C

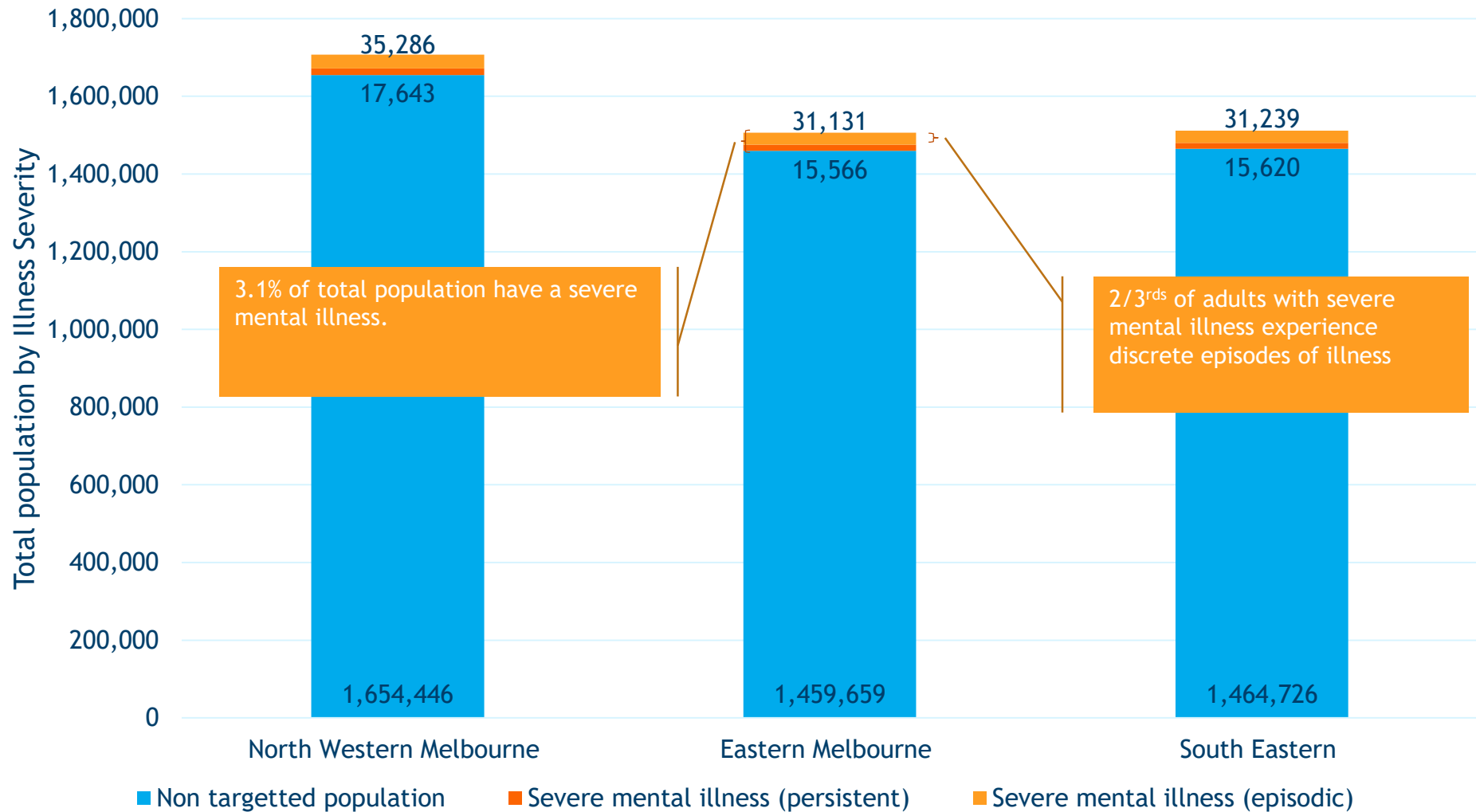
Presentation from Chris Wood, General Manager, System Outcomes, South Eastern
Melbourne PHN

The target population

Eligibility criteria for the NPS measure:

- ✓ Severe mental illness
- ✓ Complex needs
- ✓ Psychosocial impairment
- ✗ Ineligible for NDIS
- ✗ Not existing clients of PIR, D2DL and PHaMs

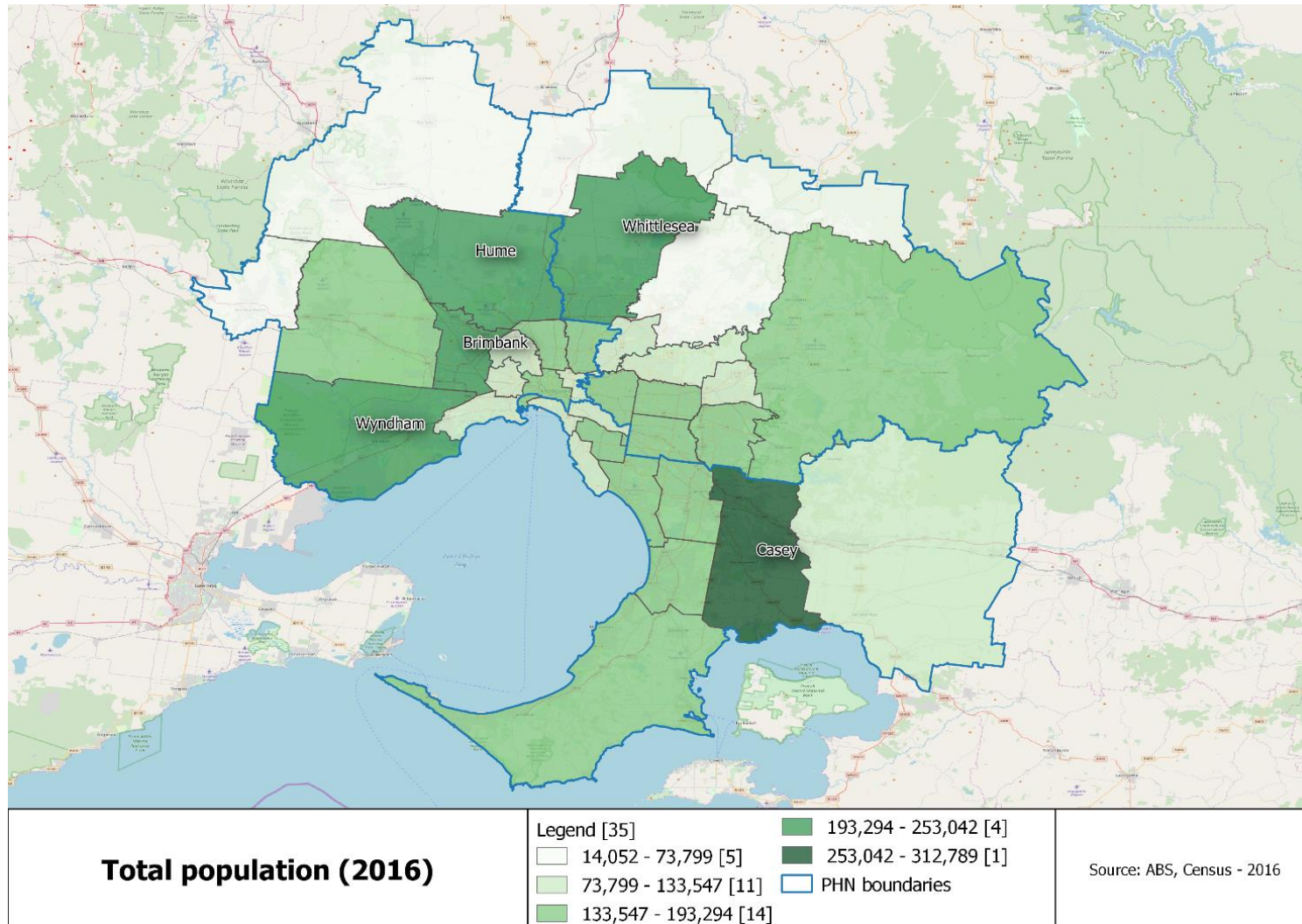
Facts and figures



slido
#NPSM

What else do you need to know about the NPS?

Total population (2016)

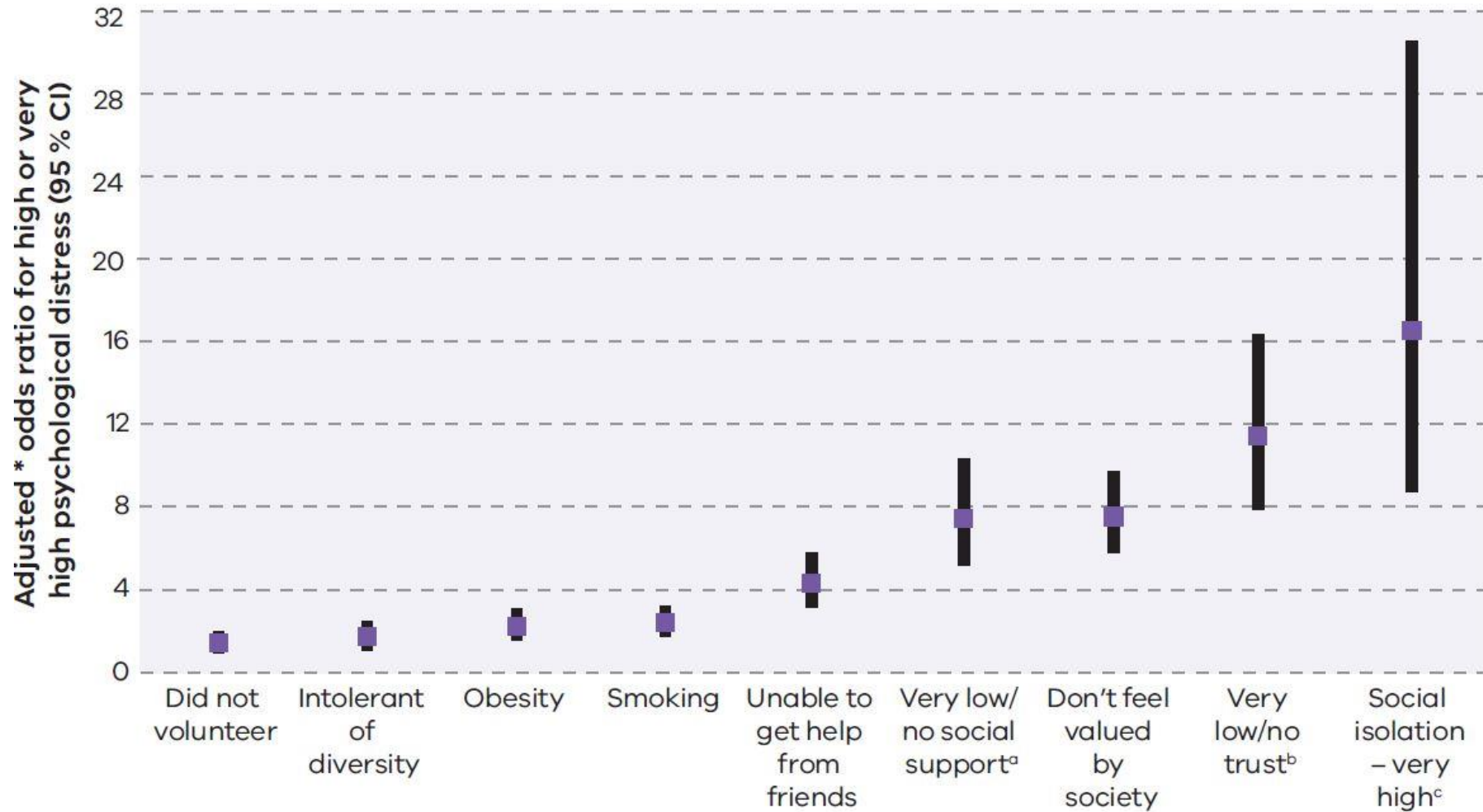


Methodology

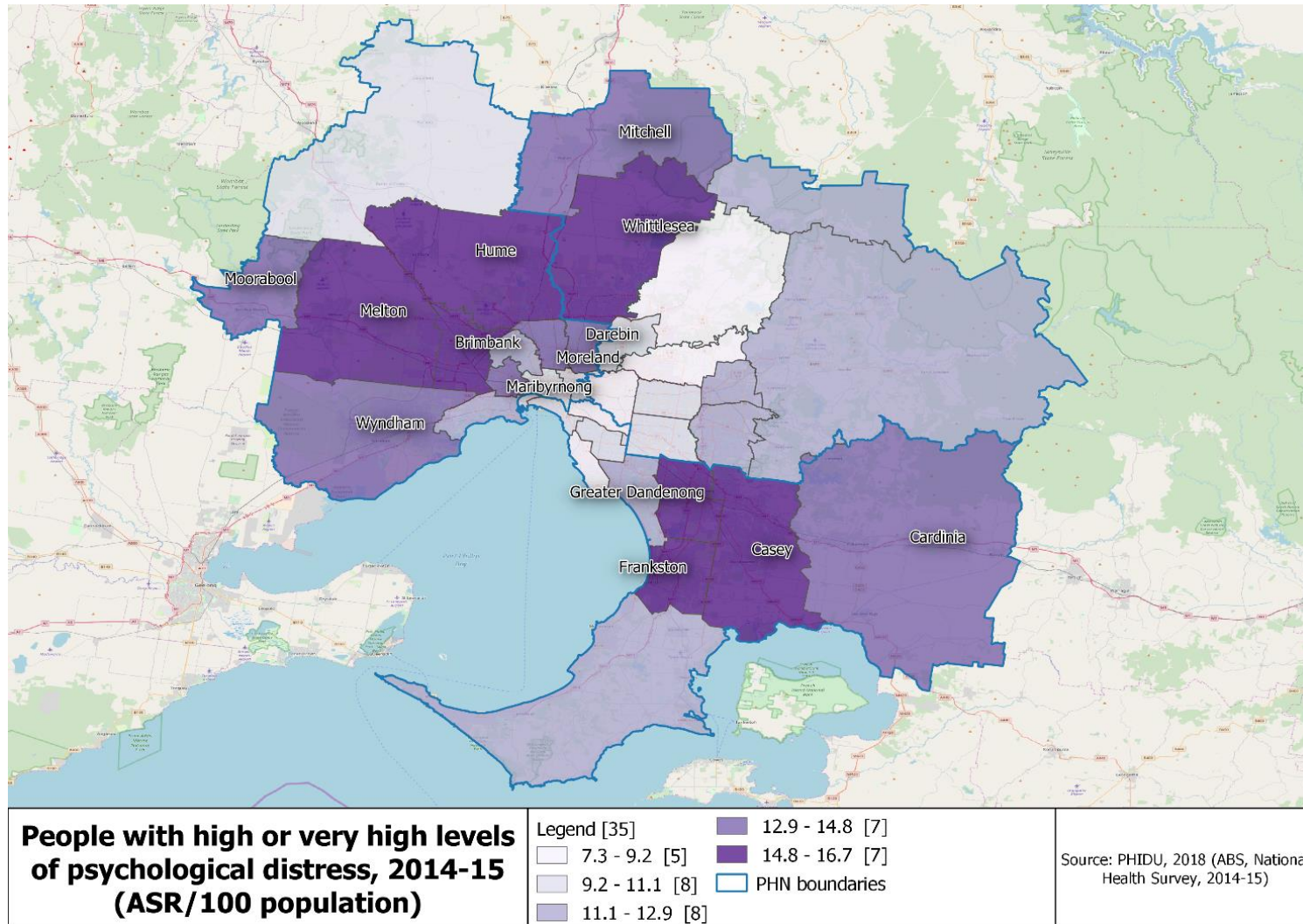
Key indicators used:

- Mental health need:
 1. Psychological distress
 2. Mental health related hospital admissions
- Social need:
 1. Unemployment
 2. Homelessness
 3. Social isolation
 4. Spoke with less than 5 people the previous day

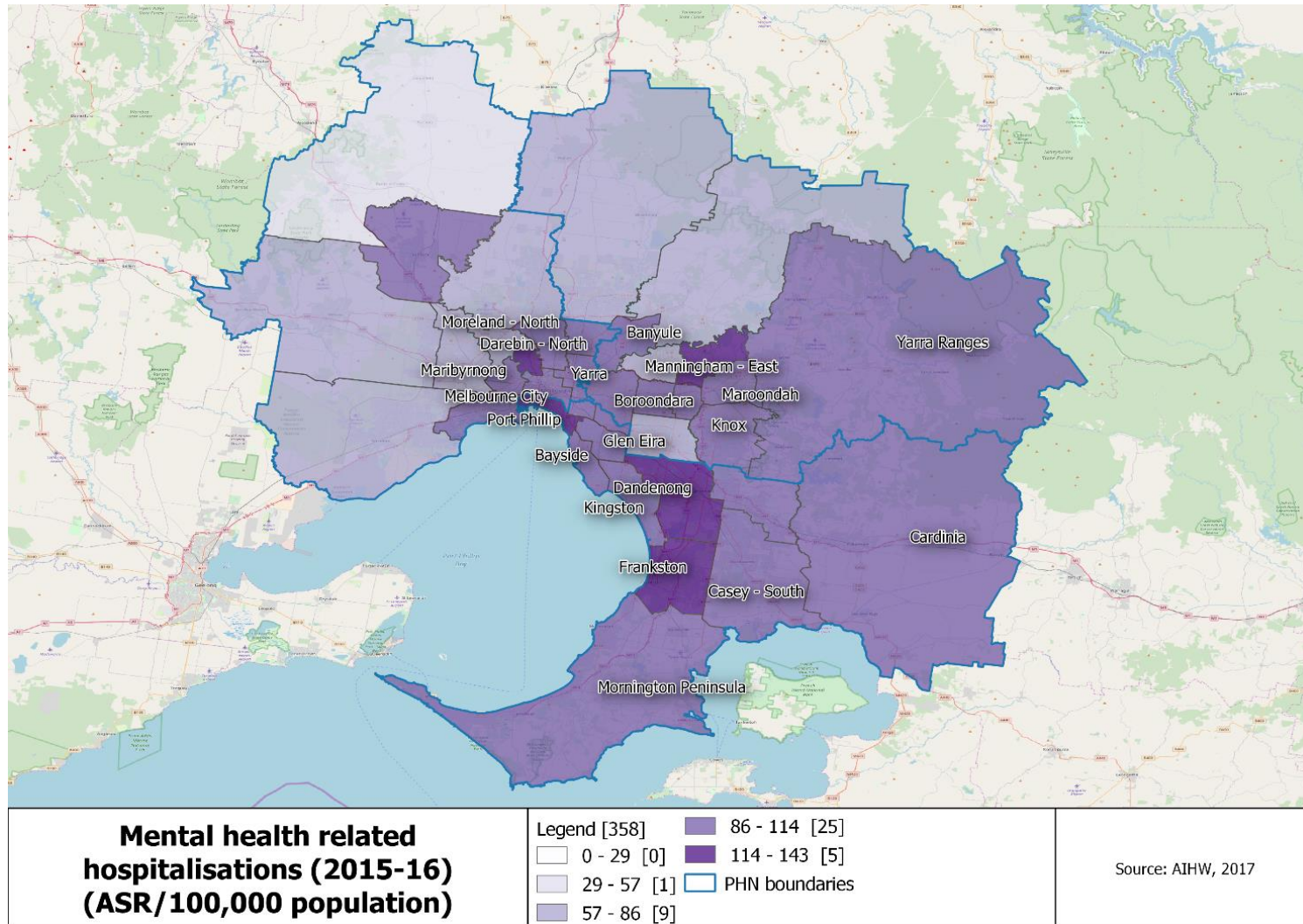
Social factors and mental health



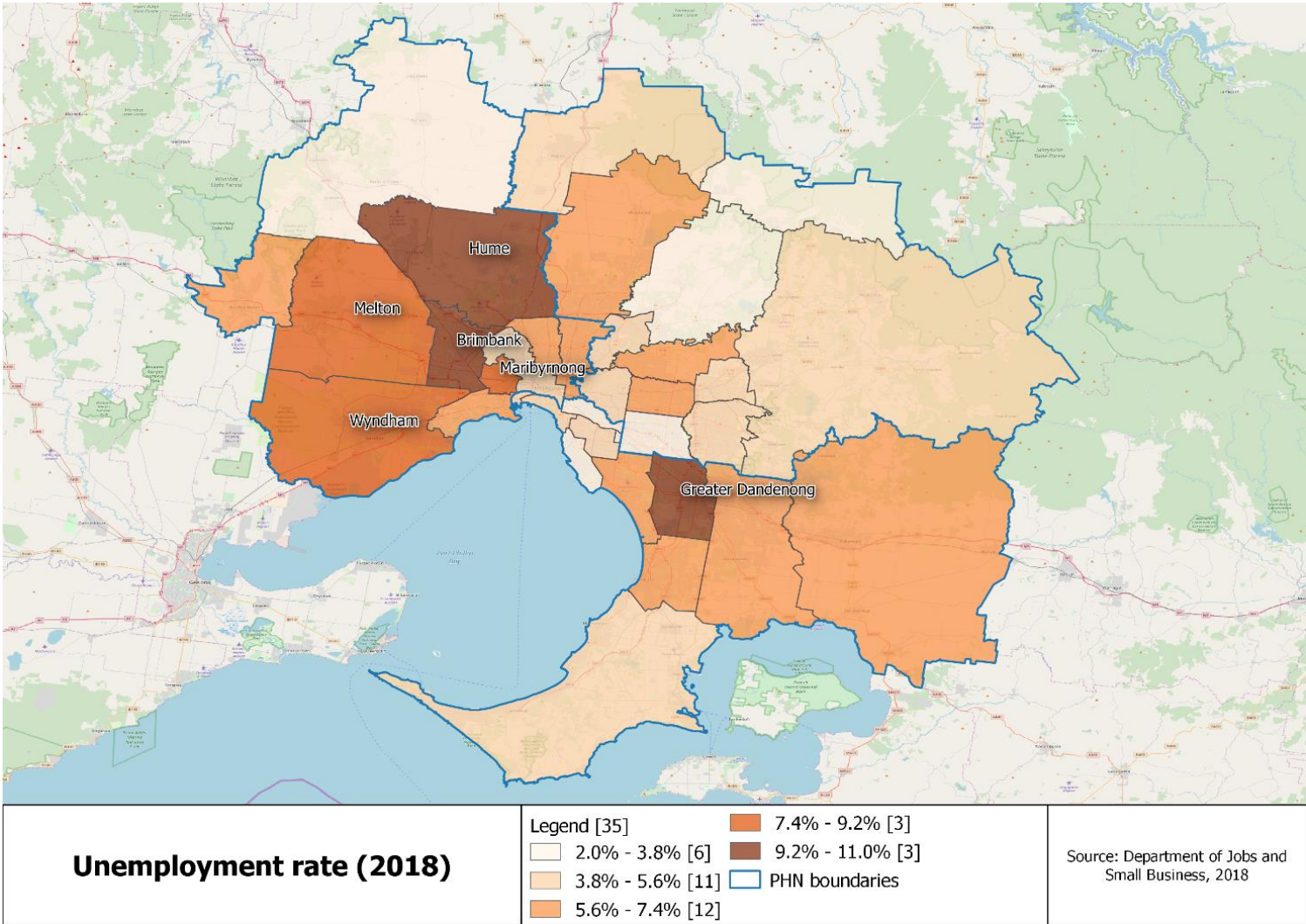
Psychological distress (2014–15)



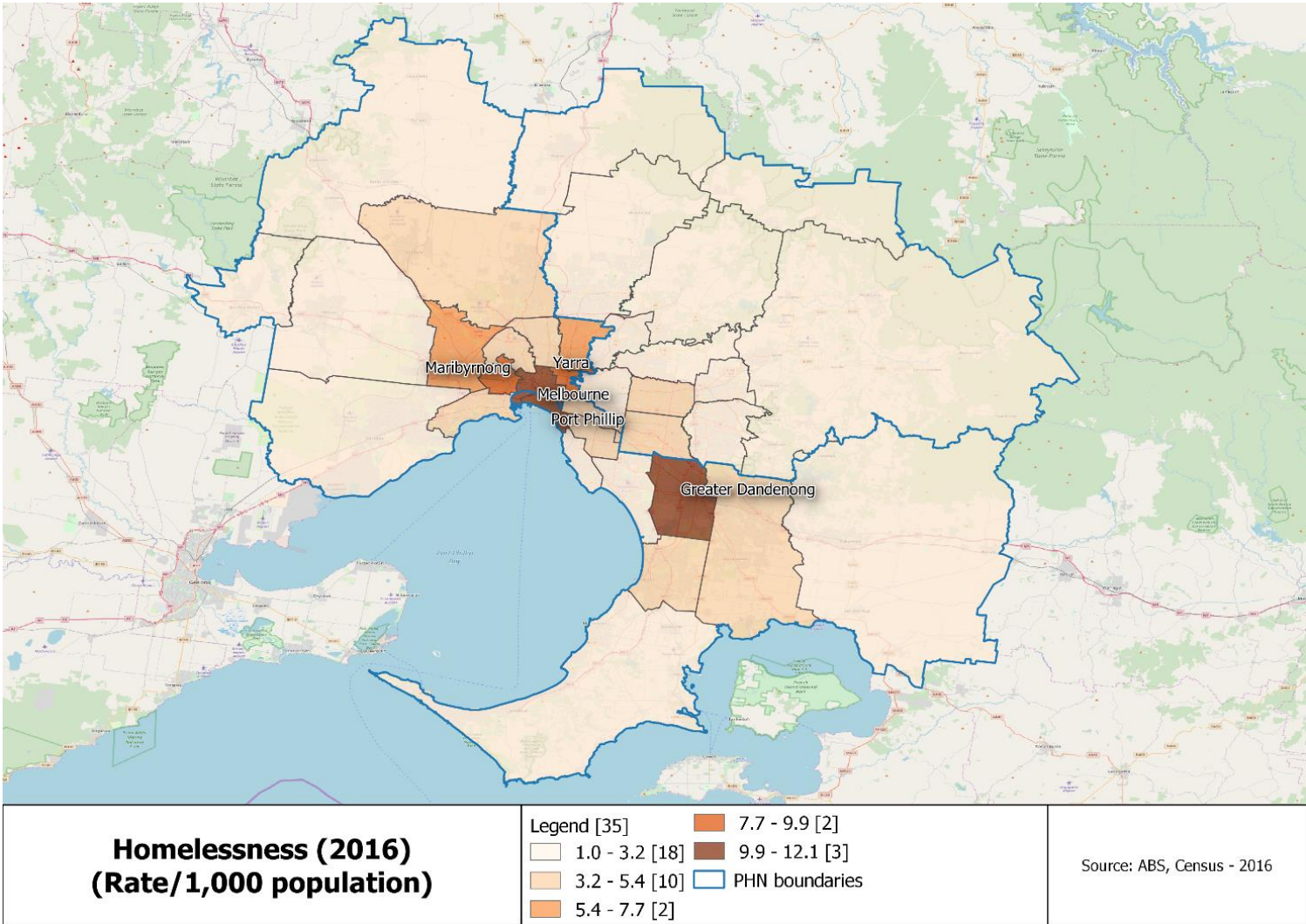
Mental health related hospitalisations (2014–15)



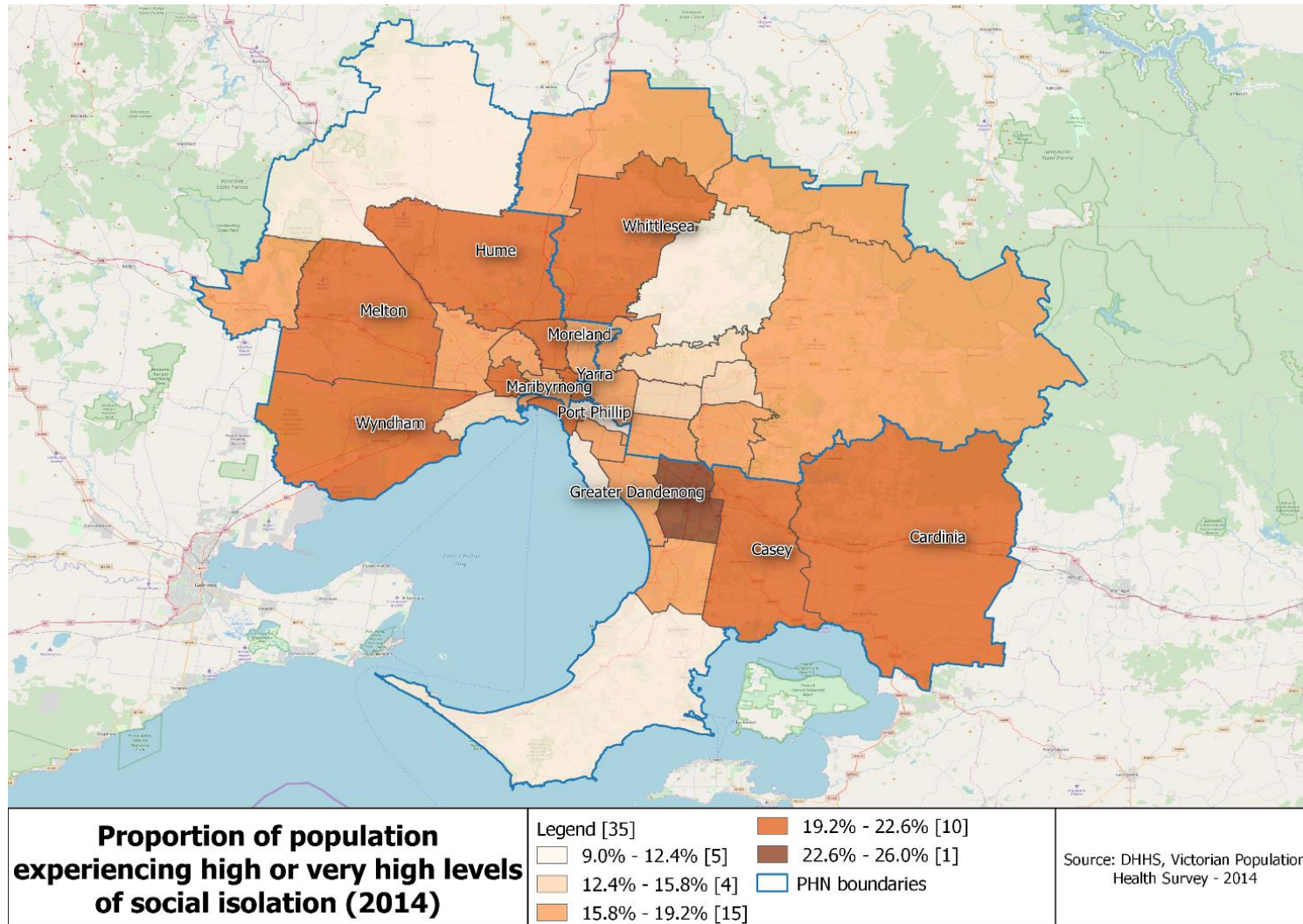
Unemployment (2018)



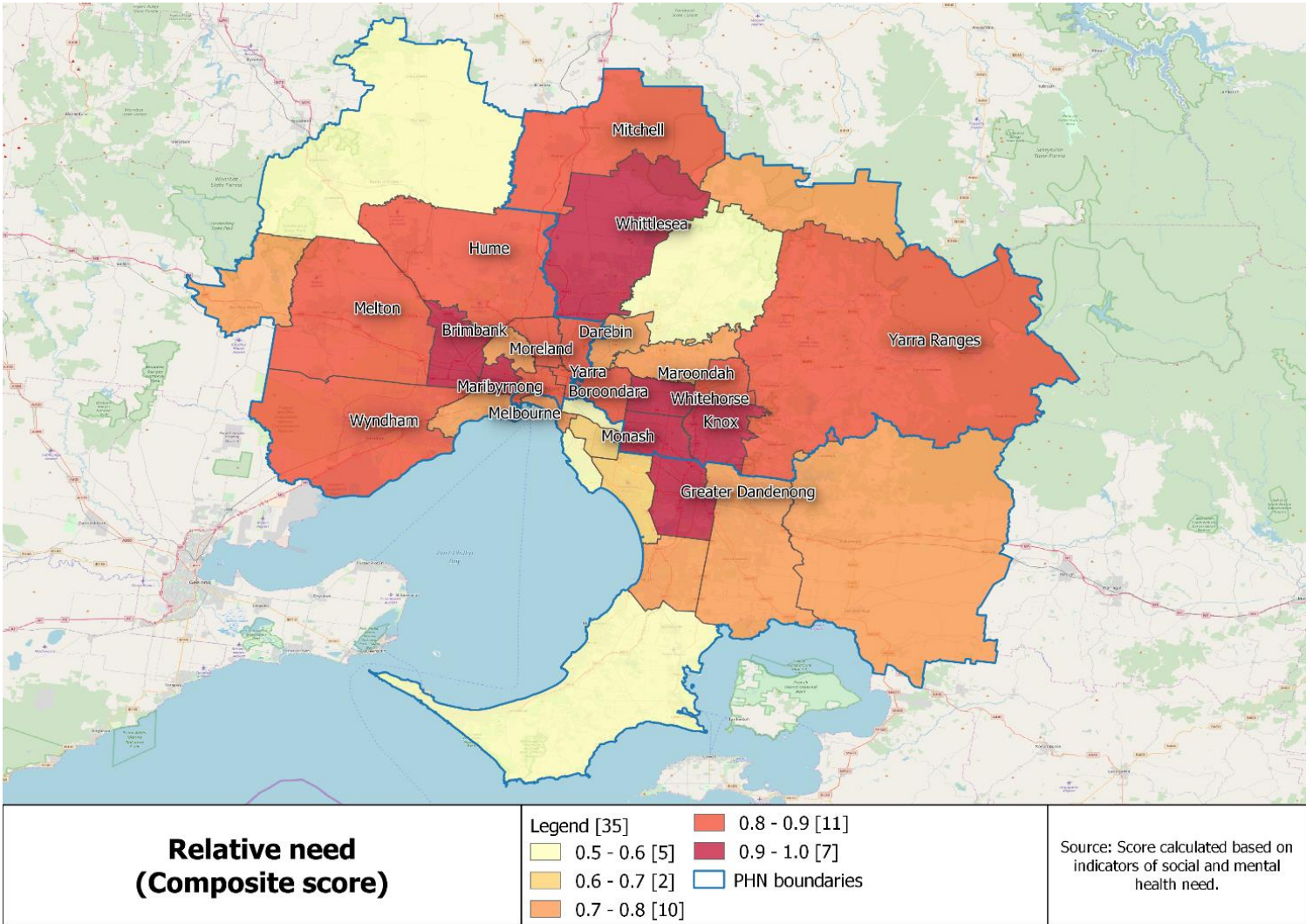
Homelessness (2016)



Social isolation (2014)



Relative need (draft)



Appendix D

Presentation from Lisa Brophy, Principal Research Fellow, The Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne and Mind Australia Limited



Supporting people with psychosocial disability – the evidence, opportunities and challenges

Lisa Brophy, Principal Research Fellow
The Centre for Mental Health, Melbourne School
of Population and Global Health, University of
Melbourne and Mind Australia Limited



Professor of Social Work
La Trobe University



- Types of psychosocial disabilities experienced by people living with mental health conditions
- **cognitive functions** (attention, memory) emotion functions (depression, anxiety, stress); **energy and drive** (motivation, apathy, fatigue); **sleep**; and **global** (emotional perception, social cognition) **activities and participation**, such as: relationships to others; employment (work efficiency, obtaining or keeping employment); looking after **personal health and self-care**; participating in **social activities**, leisure activities and other areas such as: **pain**; quality of life, wellbeing, satisfaction; activities of daily living



Current impact of psychosocial disability on life domains.

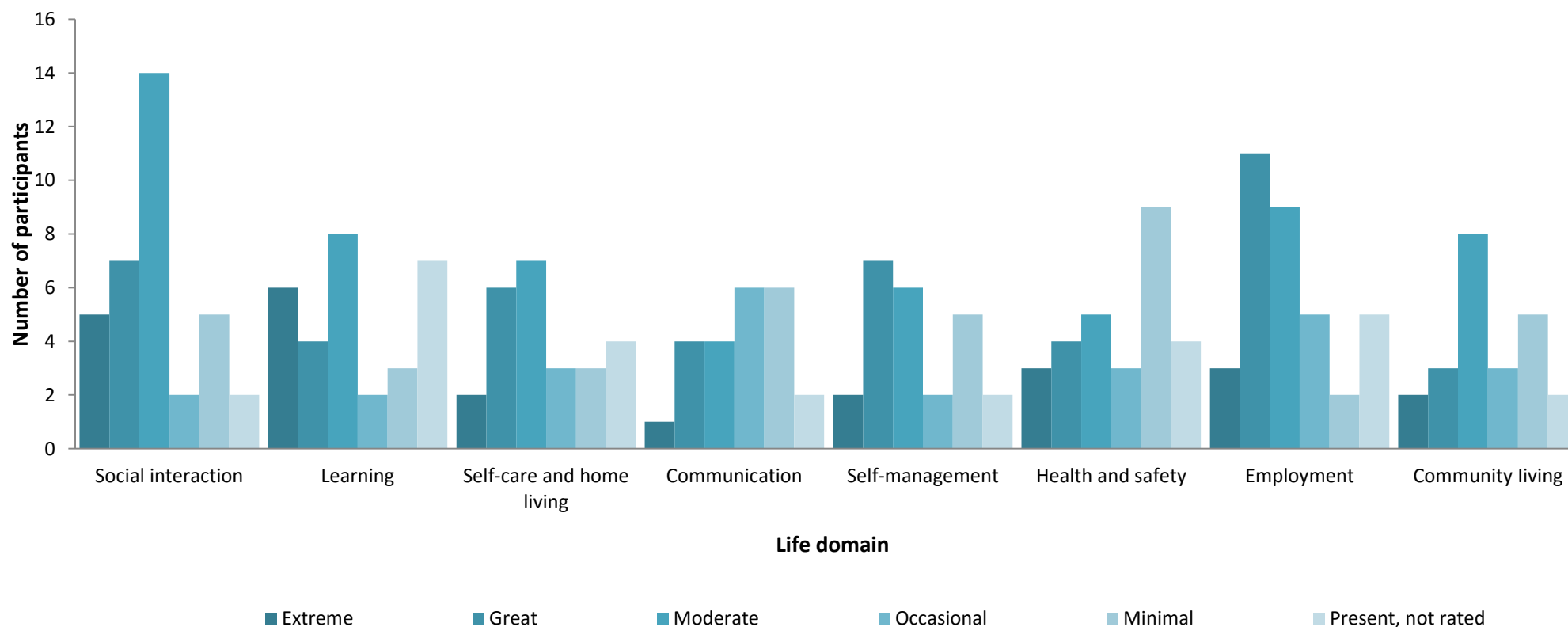
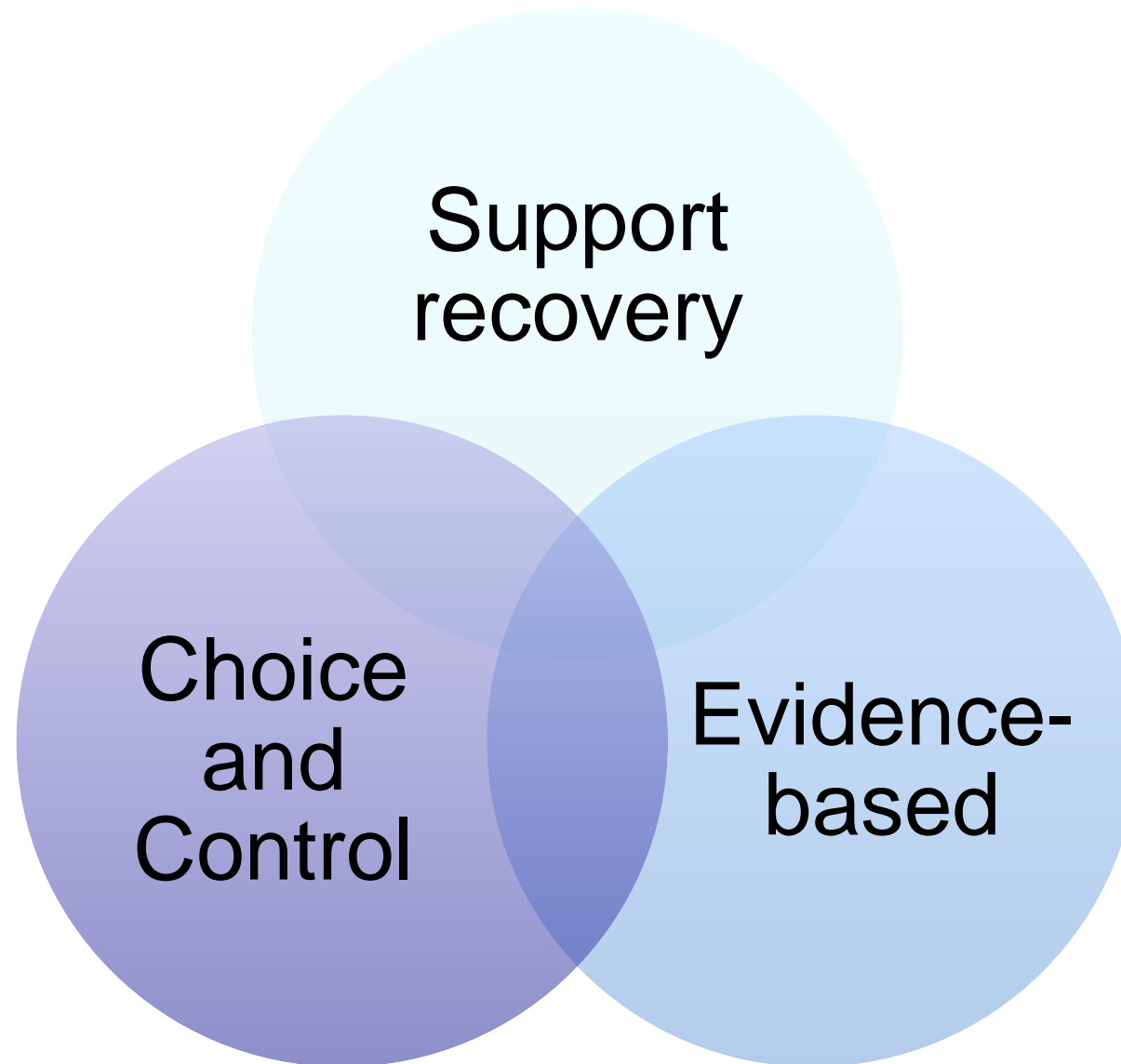


Figure 1. Participant perceptions of how much impact issues related to their mental health had on functioning across numerous life domains (n=41).

https://www.mindaustralia.org.au/sites/default/files/publications/People_making_choices_full_research_report.pdf



1. Supported Employment and education
2. Family psycho-education
3. Social Skills
4. Cognitive Remediation
5. CBT
6. Integrated Drug and Alcohol Treatment
7. Individual psycho-education/health supports
8. Intensive case management
9. Supported Housing
10. Peer Support



- What we have learned from the SHIP study – People living with psychotic illness 2010 (n= 1,825) - is that it appears that many people who may benefit from evidence based psychosocial interventions are not receiving them – even though they are usually found to be helpful

(Morgan et al 2012; Harvey et al, 2018)



Priority of needs identified by people living with SMI

- Uncontrolled symptoms
- Loneliness/social isolation
- Financial stress
- Lack of employment/ daytime activities
- Physical health
- Suitable housing
- Need for family or carer support
- Stigma/discrimination
- Access to mental health services
- Distress
- Information





- Emerging or established supportive empirical evidence:
 - Peer support workers
 - Advance directives and joint crisis planning
 - Wellness recovery action planning (WRAP)
 - Illness management and recovery
 - Refocus (PULSAR in Victoria)
 - Strengths model
 - Individual placement and support
 - Supported housing or housing first
 - Recovery colleges or recovery education programs
 - Mental health trialogues
 - Hearing voices networks

(Kay et al, 2017). (Slade et al, 2014)



- Brophy, L., Bruxner, A., Wilson, E., Cocks, N., Stylianou, M. and Mitchell, P. (2014). People making choices: the support needs and preferences of people with psychosocial disability. Mind Australia.
- Hayes L, Brophy L, Harvey C, Herrman H, Killackey E, Tellez J. Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery. Melbourne: The Centre for Mental Health, Melbourne School of Population Health & Mind Australia 2016.
- Harris, A. W., Kasic, T., Xu, J., Walker, C., Gye, W., & Hodge, A. R. (2017). Web-Based Cognitive Remediation Improves Supported Employment Outcomes in Severe Mental Illness: Randomized Controlled Trial. *JMIR Mental Health*, 4(3).
- Kay, G., Kendall, E., & Dark, F. (2017). Are Hearing Voices Networks Compatible with Cognitive Behavioural Therapy for Psychosis? *Australian Social Work*, 70(3), 312-323.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., . . . Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12-20.
- Hayes, L., Brophy, L., Harvey, C., Tellez, J. J., Herrman, H., & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry*, 1039856218759407.
- Harvey, C., Lewis, J., & Farhall, J. (2018). Receipt and targeting of evidence-based psychosocial interventions for people living with psychoses: findings from the second Australian national survey of psychosis. *Epidemiology and psychiatric sciences*, 1-17.
- Johnson, S. (2017). "Social interventions in mental health: a call to action." *Social Psychiatry and Psychiatric Epidemiology* 52(3): 245-247.
- Morgan, V. A., Waterreus, A., Jablensky, A., Mackinnon, A., McGrath, J. J., Carr, V., ... & Galletly, C. (2012). People living with psychotic illness in 2010: the second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry*, 46(8), 735-752.

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