CCQ COUNTRY TO COAST, QLD
Healthy, connected communities

MENTAL HEALTH REFORM
Research Report

Prepared for: **Country to Coast QLD**
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phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

Country to Coast QLD is an independent, not-for-profit organisation committed to building healthy, connected and resilient communities across the Central Queensland, Wide Bay and Sunshine Coast regions. We deliver the Australian Government's PHN Program and partner with health providers and the community to design and commission quality primary care services.

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1. EXECUTIVE SUMMARY

Mental ill-health remains a significant issue across Australia, with the health system struggling to meet the needs of community. There is a case for PHNs to be enabled to take a larger role in commissioning mental health services, particular given the emergence of a 'missing middle' cohort that is too unwell for out-of-hospital services, but not unwell enough for inpatient care. Country to Coast, Queensland (CCQ) is exploring opportunities to reform the types of mental health, alcohol and other drugs services it procures as a PHN, and the procurement processes it undertakes to do so, with the objective of better meeting the needs of community in the PHN's region.

This research report represents the second phase of a multi-phase process being undertaken by the PHN. Prior to this report, an investigation of key data was conducted to articulate the need for change in the PHN's area in approaches to meeting mental health needs. The report outlines key system approaches, models of care, and critical implementation elements and enablers for approaches in primary care mental health and AOD. This information is designed to serve as a base to support CCQ in subsequent phases of work, which will include community consultations (in November to December 2023) and co-design of new models of care for mental health and AOD (in 2024) across the PHN.

The evidence base for approaches, models and elements is outlined, and best practice examples and case studies relevant to a PHN commissioning context provide practical implementation examples of the delivery of evidence-based care. The research report also encompasses preventative, upstream approaches for mental health, relevant in a PHN context.

Methodology

Key Australian and international grey and academic literature was identified and analysed to understand key system approaches, models of care, and preventative approaches relevant in a PHN commissioning context. Given the scope of the topics included in this research report, recommendations developed in this report draw on key sources relevant to a PHN commissioning context, rather than attempting to undertake a systematic review of all available literature. Three streams of research in mental health and AOD were analysed:

1) System approaches
2) Models of care
3) Preventative, upstream approaches

Key findings

System approaches

Stepped care as an overarching system approach in mental health is widely recommended and has a strong evidence base. Effective implementation of stepped care has been challenging for PHNs and locally tailored approaches should draw on key principles and enabling factors across the spectrum of care and all 'steps' within the approach. Key enablers include processes and incentives for inter-service interactions, self-referral pathways, emphasising the role of primary care, and specific procurement approaches. Principles that underpin effective system approaches, such as a stepped care approach, include: person-centred care, equitable access, early (timely) intervention, evidence-based care, and a flexible, efficient and integrated system.

PHN trial sites for stepped care implementation, such Eastern Melbourne PHN, provide implementation learnings to guide locally tailored approaches.

System approaches within regional, rural and remote areas should consider elevating 'complementary' approaches to enhance the effectiveness of stepped care, in view of specific challenges in these areas. The hub and spoke approach is an evidence-based example that is highlighted in literature regarding rural and remote mental health care delivery. The approach can be enhanced through a focus on building capacity in frontline staff in 'spokes' and a supportive hub that takes responsibility for supporting both access to specialist services and building capacity in professionals working in the spokes.

Models of care

Models of care are described and represented differently across the evidence base, reflecting the complexity of designing and delivering mental health services across a population. Key evidence-based models and their critical enabling elements serve as a base to consider and co-design new, locally tailored models of care that meet the unique needs of the community across the region that CCQ serves. Case studies demonstrate examples of how these models have been tailored across different PHNs in Australia.

Models of care can be considered across four areas, noting that some models and their elements are fluid and may be relevant across several areas:

- **Models for mild to moderate mental illness:** including low intensity and self-led models, integrated and collaborative models, and psychological support models for underserviced populations
- **Models for severe and complex mental illness**: including intensive case management models, peer-led models, and psychosocial support models
- **Models for crisis care and suicide prevention:** including diversionary crisis care models, brief intervention models and community suicide prevention models
- **Models for AOD:** including dual diagnosis models and co-located models

Models of care that are described in the evidence base are not mutually exclusive and should not be viewed or implemented in isolation. Locally tailored, co-designed models of care within the context of the PHN region of CCQ may draw on multiple models, and multiple elements within these models, considering the evidence base for implementation enablers outlined in this report.

Preventative, upstream approaches

There is a strong evidence base for the effectiveness and cost-effectiveness of upstream, preventative approaches in mental health. Several evidence-based approaches exist across a wide range of settings. Three approaches are highlighted in this report, based on their relevancy to a PHN context:

- Place-based approaches
- Approaches to social isolation
- Youth approaches

Next steps for CCQ

This report has been developed as a reference document to support the execution of consultation, co-commissioning, and co-design processes. CCQ is intending several stages of consultation, commencing in mid-November. It is recommended that – using this report as a key reference – these consultations focus on presenting, testing, and refining 4-5 promising concepts (e.g. new service models, commissioning approaches, etc) with community participants. This will ensure the process continues progressing towards co-design and co-commissioning with providers that CCQ is envisioning completing in 2024.

CONTENTS

2. INTRODUCTION AND CONTEXT

Mental ill-health remains a significant, challenging issue across Australia

Over one in five Australians experience a mental health issue in any year.[i] The issue of access to mental health services is however highlighted in Australian Institute of Welfare data, which showed only 11% of Australians received Medicare-subsidised mental health services in 2021–2022.[ii] Within these figures, there is a wide spectrum of severity and duration across the population, adding to the challenge within the mental health system, as outlined in Figure 1 below.

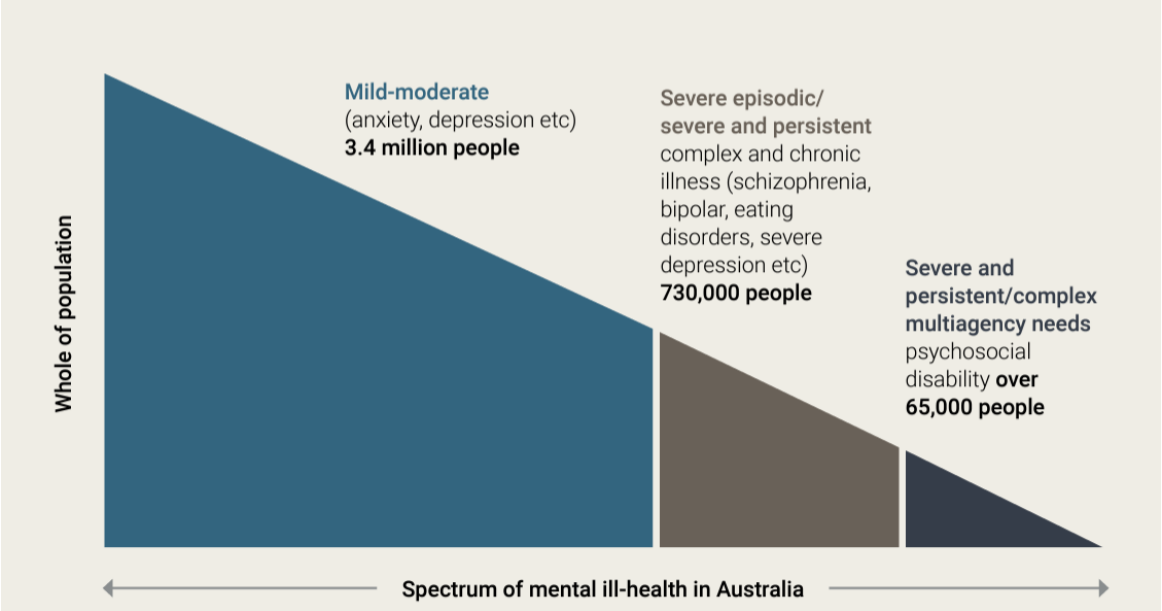

Figure 1 - Spectrum of mental ill-health in Australia: adapted from the National Review of Mental Health Programs and Services, noting figures represent 2018 data from AIHW

The mental health system is struggling to meet the needs of the community

The National Mental Health Commission's Review of Mental Health Programs and Services in 2014 found significant shortcomings in Australia's mental health system. The assessment revealed inadequate planning, poor integration, and an inability to adequately address the requirements of individuals with mental health issues. The report highlighted the necessity for substantial and foundational changes to the mental health system, adopting principles centred around individuals, a new system architecture, and reallocating funding towards more efficient and effective upstream services.

Mental health conditions are complex – people with mental health commonly interact with multiple different touch points across the health and social system. Mental health, health and non-health systems are however mostly delivered in a fragmented and siloed nature, with mixed and overlapping responsibilities.[iii] The result is inefficient delivery and use of services, and sub-optimal mental health outcomes for individuals. Ultimately, this further challenges stressed services and systems, compounding the issue.

Challenges in the system have created a 'missing middle' cohort

The 'missing middle' is a cohort that has received growing attention in view of the funding arrangements for mental health care in Australia. There is a disconnect between out-of-hospital services (that are federally funded) and inpatient-oriented services and systems (that are state-funded). This creates a gap for people who need intensive support in the community but are not 'unwell enough' for inpatient care: the 'missing middle'.[iv] It has been highlighted that there is a case for PHNs to be enabled to take a larger role in commissioning mental health services, including for community mental health services that may previously have been under the remit of state funding. This adjustment has the potential to better meet the needs of individuals in this 'missing middle' cohort. v

There is an opportunity for CCQ to reform the services it procures.

Over the past two decades, significant changes and reforms have occurred in Australia's mental health system, including growth in the mental health workforce, delivery of psychiatric care primarily in the community (therefore reducing the need for acute psychiatric hospital care), and improved access to mental health care in primary care settings. Alongside these changes, the awareness of mental wellbeing has improved significantly amongst the general population.

Acknowledging the challenges being experienced in the community, and the system's shortfalls thus far in addressing these needs, there is an opportunity for CCQ to innovate and diversify the services it procures. To explore this opportunity, the research conducted for this report has focussed on determining findings within three key sections:

(i) **System approaches and principles**, including implementation considerations, enablers, and approaches for rural and remote areas

(ii) **Models of care** across mild to moderate mental illness, severe mental illness, crisis care and suicide prevention, and AOD

(iii) **Upstream preventative approaches**

The findings of this research report provide an overview of key system approaches and principles, models of care, and prevention or 'upstream' approaches for consideration in the context of PHN commissioning.

This research report does not attempt to provide an exhaustive list of all system approaches and models that exist in mental health, but instead aims to highlight key approaches and models. It is also important to note that approaches and models presented in this report are not distinct and not mutually exclusive in their implementation. Rather, in practice, implementation will often draw on multiple dimensions of models based on the needs of the local community, as highlighted in case studies throughout this research report.

3. SYSTEM APPROACHES AND PRINCIPLES

3.1 OVERVIEW

Key principles that underpin all mental health system approaches are outlined in the table below, alongside key findings of individual system approaches. Stepped care is highlighted as the overarching and predominant system approach, with other 'complementary' approaches to a stepped care approach also being highlighted by the literature.

<table>
<tr><th colspan="2">Summary of findings: System approaches</th></tr>
<tr><td colspan="2">Key principles:

Several key principles are present across all system approaches:

• Person-centered
• Equitable access
• Early intervention (timely)
• Evidence-based (effective)
• Flexible and efficient
• An integrated system (coordinated)</td></tr>
<tr><th colspan="2">Key approaches</th></tr>
<tr><th>Stepped Care</th><th>Other ‘complementary’ system approaches</th></tr>
<tr><td>Key findings:

• Stepped care is a widely recommended approach in Australia and internationally.
• Evidence-based, effective, and considered best practice
• Several critical enablers should be considered in stepped care implementation, such as processes and incentives for inter-service interactions, self-referral pathways, emphasising the role of primary care, and specific procurement approaches.
• National PHN trial sites provide practical implementation examples.</td><td>Key findings:

• Regional, rural and remote areas in particular may require other system approaches alongside stepped care.
• Hub and spoke approaches are commonly highlighted in regional and rural contexts.
• Outreach models (for example fly in fly out) and telehealth are likely to be involved in many rural and remote approaches.</td></tr>
</table>

3.2 KEY PRINCIPLES

Several key concepts have been highlighted across the literature as critical guiding principles at a systems level for mental health approaches. Whilst there are many important principles, the following are most often highlighted across the research reviewed:

(i) Person-centred
(ii) Equitable access[vi]
(iii) Early intervention (timely)
(iv) Evidence-based (effective)[vii]
(v) Flexible and efficient

(vi) An integrated system (coordinated)

Building on these principles, systems approaches can also be considered across three domains: (i) early in life, (ii) early in illness, and (iii) early in episode.[viii]

Encompassing these principles, the central 'overarching' system approach of stepped care is elevated in the literature as the primary system approach to mental health, however other approaches such as hub and spoke can enhance the effectiveness of stepped care in certain scenarios.

3.3 STEPPED CARE

3.3.1 THE ROLE OF STEPPED CARE IN MENTAL HEALTH

Stepped care is an evidence-based, staged system to provide mental health care. It is a key element of the mental health reform initiative to fund PHNs for regional mental health planning and commissioning.[ix] The aim of a stepped care approach is to build a range of help and support options of varying intensity to match the level of need and complexity of mental health conditions in the community. Stepped care approaches ideally support early intervention through their ability to meet the needs of individuals with earlier, lower intensity interventions before their care needs escalate. A key overarching principle of stepped care is providing the right level of care at the right time.

3.3.2 THE IMPLEMENTATION OF STEPPED CARE

Key elements of an effective stepped care approach include:

- **Responsive**: to the needs of people, their families, carers and professionals
- **Adaptable:** the model fits around the person and not the person around the model
- **Seamless transitions and continuity:** minimising the need for transition between different services or providers; and easy movement between levels and to other pathways (e.g. physical health)
- **Prompt assessments:** that are not repeated unnecessarily to access interventions
- **Designated staff to coordinate engagement:** with, and within, the pathway
- **Holistic criteria:** are used to determine movement between steps
- **Ongoing monitoring:** outcomes focused, with mechanisms for responding to changes in needs
- **Information sharing:** with the person, GPs and other health professionals
- **Training and support:** provided to staff on the operation of the pathway

Implementation of stepped care can be enhanced through several key enablers that build on the key elements of stepped care.[x]

- Establishing well defined processes for effectively engaging and involving all stakeholders
- Using incentives to encourage inter-professional and inter-service collaboration that facilitates the redirection of service users in line with a stepped care approach
- Promoting self-referral for low intensity care by increasing awareness within the community of availability of low-intensity pathways
- Advocating for individuals with severe mental illness to be enrolled or registered with a primary care provider, to enhance care coordination and collaborative care across physical and mental illness
- Using capitation payments, weighted by outcomes, to incentivise enrolment

- Developing clear processes for managing contracts with external providers, with a focus on maintaining system and program integrity

3.4 OTHER SYSTEM APPROACHES

Whilst stepped care is presented as the overarching system approach, other approaches should be considered alongside stepped care and may have increased relevance in specific populations.

Hub and spoke approaches can play a role in regional and rural areas.

Hub and spoke models, also known as hub and satellite models, are well suited to larger geographical areas in regional locations, with the ability to cover neighbouring rural and remote areas where mental health services are limited. In hub and spoke models, service provision is provided both in the central town or region (as the hub), often providing specialised services, and the 'spokes' service areas beyond this. This may be through local clinics or health centres and service providers travelling to outlying communities as outreach.

From a practical implementation perspective, it has been suggested that the 'hubs' include services such as acute care and mental health teams, and provide support to rural and remote 'spokes'. In the rural spokes, the majority of the mental health services in the spokes would be provided by generalist primary health care service providers, with some embedded specialist mental health workers, and the rural workforce supported by the hubs. In the remote spokes, specialist mental health services would only be available on a visiting or virtual (telehealth) capacity.[xi] Importantly, in implementation of hub and spoke models, mental health service providers in the hub (located in the urban or regional hub) take on the responsibility for supporting providers in rural areas (the spokes), for example through telehealth consultation services, clinical supervision and training support.[xii]

Several practical planning aspects and enablers should be considered in design with hub and spoke approaches, to promote integrated care. These include the capacity of the hub to support the spokes, the level of experience of staff from the hubs travelling to the spokes, transportation, the working culture within the hub and spoke network, effective corporate and clinical governance, and effective communication strategies.[xiii] A regional PHN report highlighted the need for accountability to ensure services are delivered as contracted, especially in the spoke sites, to ensure equitable access.[xiv]

Network approaches provide an alternative to hub and spoke approaches but are less common. Recent reporting on the success of Lifespan suicide prevention trials notes that greater success was found where PHNs in their coordinating role moved from a hub and spoke approach to a network approach, where partners formed relationships and engaged equally, with shared goals across partners. These insights demonstrate potential challenges and considerations in a hub and spoke approach.[xv] Network approaches move beyond the hub and spoke model, with a series of networks that have come together voluntarily. These networks are formed either through a shared interest or they have been created by an overarching system or funder. Networked approaches are seen as more collaborative and 'equal', compared with the hub and spoke approach which tends to be more hierarchical.[xvi] It should be noted that terminology across hub and spoke and other alternative system approaches varies across the literature, and terms such as clusters, networks and satellites are at times used to describe hub and spoke or variations of hub and spoke models.

4. MODELS OF CARE

4.1 OVERVIEW

Models of care in a broad sense are models for arranging services, with the aim of maximising the effectiveness and efficiency of service delivery and service utilisation. To note, the terminology of service models and 'models of care' is not uniformly defined across the literature. This research report takes a pragmatic approach to capturing key findings in the literature related to the organisation of services in primary care mental health. This report also does not provide an exhaustive list of all models of care, but instead captures key models of care relevant to a PHN context.

Models of care are also generally not mutually exclusive. Optimal delivery models for different contexts may draw on various elements across *multiple* models of care. For the purposes of this research report, models of care have been arranged across several groups to highlight different elements and represent the research base, however implementation should not be viewed through a lens of choosing one individual model of care as exclusive delivery.

Many of the models of care presented below are not necessarily novel or innovative, but importantly they have a strong evidence base and incorporate key foundational elements to guide the development of regionally tailored models in the context of PHN reform. Case studies within the following section highlight practical applications and implementation where PHNs have developed innovative models and delivery methods, tailored to their regions, based on the evidence base.

Models of care presented in this section are arranged as follows:

1. Models in mild and moderate mental illness
2. Models in crisis care and suicide prevention
3. Models in severe and complex mental illness, and
4. Models in alcohol and drugs (AOD)

For each sub-section, common elements, models for consideration, and key findings / case studies within each are identified.

4.2 MODELS IN MILD AND MODERATE MENTAL ILLNESS

4.2.1 OVERVIEW

The following table outlines key models that are of high relevance to PHN commissioning, in mild and moderate mental illness. Further detail regarding these models, implementation considerations and enablers and relevant case studies is presented in this section. Models and their key elements may also have relevance in other spectrums of mental illness, however they are key models to highlight in the context of mild and moderate mental illness.

Summary of findings: Models in mild and moderate mental illness		
Key common elements: • Peer workers and 'connectors' are highlighted as beneficial for mild-moderate contexts		
Key models		
Low intensity and self-led models	**Integrated and collaborative care models**	**Psychological support models for underserviced populations**
Key findings: • Strong evidence base with demonstrated reductions in use of less appropriate services • E-mental health care is an effective and important component • Navigation pathways, efficiency and complexity are a key consideration	**Key findings:** • Strong evidence base; common, effective, and demonstrated to improve access to mental health services • Important enablers include care coordination or case management, relationships and service knowledge, communication across treatment teams, and a flexible/navigable service environment • Co-located models can elevate aspects of integrated and collaborative care, however are complex to implement effectively	**Key findings:** • Limited evidence for how to organise the provision of psychological services to ensure equity of access and reduce attrition • Case studies demonstrate potential approaches

4.2.2 LOW INTENSITY AND SELF-LED MODELS

Low intensity and self-led models have a strong evidence base and can reduce the disproportionate use of less appropriate mental health services for people with mild mental illness.

Low intensity, non-clinical early interventions are recommended as first-line treatment for people with mild mental health conditions.[xvii] There is an identified need for flexible evidence-based services that are appropriate to individuals at risk of mental illness, or with mild mental illness. This issue is also evidenced in previous mental health needs assessments for CCQ, where some rural areas of the PHN have limited access to

primary care mental health services, therefore leading individuals with mild to moderate mental health needs to access services targeted for severe and complex needs.

Models should include a wide range of treatments or interventions across different modes of delivery to ensure choice and acceptability to individuals who are seeking help. Evidence-based interventions are numerous, including exercise-based, coaching and online interventions.[xviii]

4.2.3 INTEGRATED AND COLLABORATIVE CARE MODELS

Models involving integrated and collaborative care are common, effective and enable improved access to mental health services.

There are several terms and types of services that relate to integrated and collaborative models. For example, integrated care, collaborative care, shared care, consultative care and coordinated care are terms that are used interchangeably throughout the literature but are often more rigidly defined in academic sources. Groupings are outlined below with the aim of better understanding the evidence base and elements associated with these models.

Integrated care is often used as a broad term referring to any model of care that brings together different healthcare providers and organisations, with the aim of providing more comprehensive and coordinated care. Collaborative care is often represented as a model of care within integrated care.

Collaborative care models build a team of professionals around individuals to manage both their physical *and* mental health.

Collaborative care and integrated care models have a strong evidence base.

Collaborative care consistently shows superior outcomes for both mental health and other conditions, for example diabetes, cardiovascular disease.[xix] It has also been highlighted as a cost-effective model of care through Australian and international research.

There is strong evidence that the integration of primary health and specialist mental health care is positively associated with improved quality and continuity of care and reduced health inequalities.[xx]

Key overarching enablers of collaborative and integrated care models are relationships, a service environment that is person-centred, and easy service navigation.

- *Relationships and service knowledge*: for both community and staff operating in the mental health and broader system, with a focus on a stable workforce to enable collaborative relationships and sharing of learnings, with standardised worker knowledge across sectors. Clarification of professional roles, with strong leadership, is an important aspect within this enabler, so each team member clearly understands their role[xxi,xxii]
- *Communication:* mechanisms and frameworks to support effective communication across teams regarding a patient's needs and progress over time, for example through shared care plans that enable regular assessments of progress[xxiii]
- *A gentle and flexible service environment*: that enables connection and embeds trauma informed practice, with consideration for co-location of services[xxiv]
- *Service navigation*: with simple and comprehensive tools to enable navigation of supports (for both

4.2.4 PSYCHOLOGICAL SUPPORT MODELS FOR UNDERSERVICED POPULATIONS

Despite the effectiveness of stepped care and the role of psychological support within this approach being widely accepted, there is limited research about the best way of organising the provision of psychological services to ensure equity of access and reduce attrition in services.[xxv] This highlights the relative disparity between research on effectiveness of mental health care, versus *access* to that care.

4.3 MODELS IN CRISIS CARE AND SUICIDE PREVENTION

4.3.1 OVERVIEW

There is a strong evidence base across crisis care and suicide prevention of effective interventions across the spectrum of care. Key models relevant to a PHN context are outlined in the table below, including diversionary crisis models that offers an alternative to emergency department settings, brief intervention models, and broader community-based suicide prevention models.

<table>
<tr><th colspan="3">Summary of Findings: Models in crisis care and suicide prevention</th></tr>
<tr><td colspan="3">Key common elements:
• Local tailoring, co-design, and place-based strategies are emphasised
• Models should involve partnerships across primary health, hospital networks, and other local organisations</td></tr>
<tr><th colspan="3">Key models</th></tr>
<tr><td>Diversionary crisis care models</td><td>Brief intervention models</td><td>Community-based suicide prevention models</td></tr>
<tr><td>Key findings:
• Alternative / ‘diversionary’ models are growing in emphasis, with evidence of effectiveness, including reducing ED admissions and suicide risk
• Models may require both co-design and co-commissioning due to their need for tailoring to local contexts</td><td>Key findings:
• Distress Brief Intervention models have an emerging evidence base</td><td>Key findings:
• Models should adopt a regional, community-based approach
• Prevention should be embedded across the spectrum of care, and include both clinical and non-clinical supports
• Gatekeeper training has been identified as one of the most promising strategies
• Suicide Prevention Trial Sites provide a base to consider different models in a PHN context
• Community suicide prevention models in rural and remote</td></tr>
</table>

		communities should focus on linking existing programs, key stakeholders and sectors, integrating suicide prevention strategies in existing services

4.3.2 ELEMENTS OF SUICIDE PREVENTION AND CRISIS CARE

Beyond Blue's submission to the Productivity Commission provides a useful diagram (see figure 2) to consider the multiple elements of suicide prevention and crisis care, noting that there are also much broader 'upstream' elements in community suicide prevention.[xxvi]

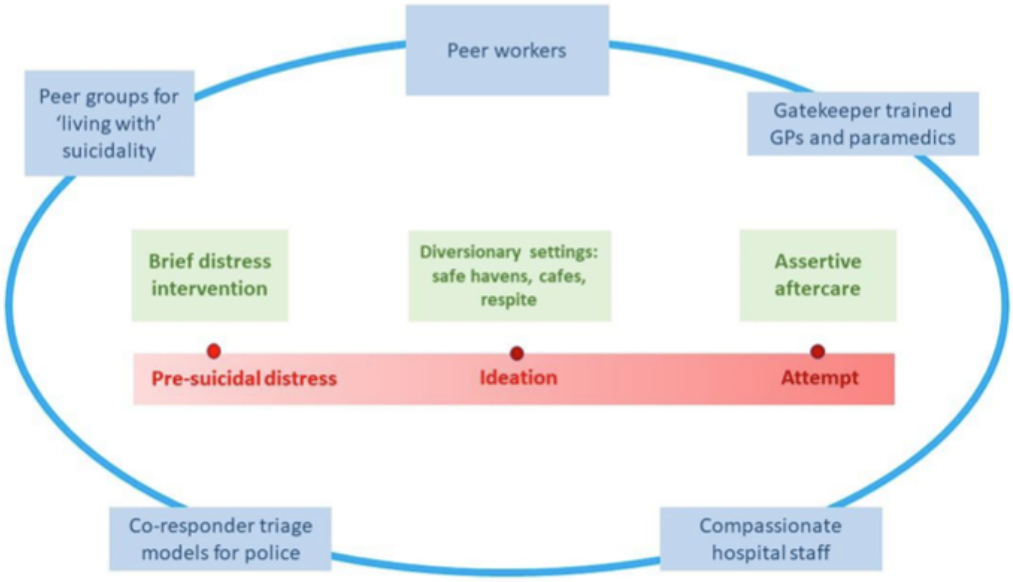

Figure 2 - Beyond Blue's proposed universal suicide prevention system

4.3.3 DIVERSIONARY CRISIS CARE MODELS

Crisis care can be considered under four stages based on the continuum and patient journey. There are key practice implications at each stage:[xxvii]

- Access to support before a crisis point: receiving care with minimal delay and quick referral (either through self-referral or building links between services).
- Urgent and emergency access to crisis care
- Quality treatment and care in crisis
- Promoting recovery and preventing future crisis

Alternative diversionary models to mental health crisis care can improve patient outcomes and reduce ED admissions.

Alternative models of care, sometimes called 'diversionary' models, have received growing attention to better support people who may be experiencing a mental health crisis, and in particular experiencing a suicidal or self-harm related crisis. One well-evaluated example of an alternative model is the Maytree Suicide Respite Centre in the UK. The model prioritises the inclusion of people with lived experience in the service design. The model has been shown to have short and long-term benefits, including reduced suicide risk.[xxviii]

Design of alternative models to crisis care will likely require a co-design approach. Key implementation considerations and elements of service delivery models across Australia have been previously profiled in work by Consumers of Mental Health WA to inform WA model design, serving as a base to consider for a local co-designed model.[xxix]

4.3.4 BRIEF INTERVENTION MODELS

Distress Brief Intervention models have an emerging evidence base as a promising alternative crisis model.

Distress Brief Intervention models involve a time-limited and supportive problem-solving approach with individuals experiencing psychological distress.

The Distress Brief Intervention model has two levels, as highlighted in the Victorian Royal Commission:[xxx]

- Level 1 – Trained frontline staff assist people in distress and then ask if they would like further support. They can then be referred to the Distress Brief Intervention service.
  The service contacts the individual within 24 hours to start providing face to face support.
- Level 2 – After contact within 24 hours, trained community sector staff provide community-based problem-solving support, wellness and distress management planning. Connections and signposting to other services also occurs (support and connections to services can be broad, e.g. issues such as homelessness, relationship issues and family violence).

The model has not undergone extensive evaluation however early evaluation findings suggest the Distress Brief Intervention model is effective at reducing distress and may prevent suicidal behaviour.[xxxi,xxxii]

Community-based Suicide Prevention Models

Suicide prevention models should adopt a regional, community-based approach.

Suicide prevention models should adopt a regional approach, focusing on moving towards a more integrated and systems-based approach in partnerships with hospital networks and other local organisations.[xxxiii] Within community-based models, suicide prevention should be embedded across the spectrum of care.

A strong focus on aftercare and follow up is crucial within a service model, given a suicide attempt is the strongest risk factor for subsequent suicidal behaviour. xxxiv

Up to 25% of people who present to ED make another attempt following discharge.[xxxv] Aftercare services have been shown to decrease further suicide attempts by up to 20%, and studies have consistently shown that outreach aftercare models are effective in reducing hospitalisations.[xxxvi]

Community-based suicide prevention models should encompass clinical and 'non-clinical' services and supports, delivered in an evidence-informed way.

Community-based suicide prevention can contribute to reducing suicide rates by addressing risk factors and promoting protective factors at the community level. This creates a supportive environment that encourages individuals to seek help and reduces the likelihood of suicidal behaviour. The evidence base in community-based suicide prevention is emerging, and still has gaps. Many approaches are therefore 'evidence-informed' through what is considered good practice. Some principles of good practice in community-based suicide prevention models include:[xxxvii]

- credible and trustworthy (in the communities they operate in)
- evidence-informed activities
- appropriate delivery methods (reaching people 'where they are')
- addresses a local need
- trained and skilled personnel
- culturally safe and appropriate.

4.4 MODELS IN SEVERE AND COMPLEX MENTAL ILLNESS

PHNs are responsible for the commissioning of mental health services for people with severe or complex mental illness within a primary care context. Key models relevant to a PHN commissioning context are outlined in the table below.

<table>
<tr><th colspan="3">Summary of findings: Models in severe and complex mental illness</th></tr>
<tr><td colspan="3">Key common elements:
Should include high-intensity psychological services and clinical care coordination, linking with psychosocial supports
Models for young people at risk or with severe mental illness should be designed and delivered through a 'youth lens'</td></tr>
<tr><th colspan="3">Key models</th></tr>
<tr><td>Intensive case management models</td><td>Peer-led models</td><td>Psychosocial supports</td></tr>
<tr><td>Key findings:
Intensive case management/Assertive Community Treatment (ACT) models have a strong evidence base in severe mental illness</td><td>Key findings:
Peer-led models have been consistently highlighted in mental health Royal Commissions within the context of severe mental illness</td><td>Key findings:
Models encompassing psychosocial supports are important in severe and complex mental illness, particularly for individuals who are ineligible for the NDIS</td></tr>
</table>

	• Appropriate training, supervision and mentoring is important for peer models	• Social prescribing models are emerging in primary care contexts • Services Homelessness Pilot

4.4.1 KEY COMMENT ELEMENTS

Models for severe and complex mental illness should include provision of high intensity psychological services and clinical care coordination.[xxxviii,xxxix]

Recovery oriented, strengths-based approaches in models are particularly important for people with severe mental health conditions who are being supported in primary care (focusing on strengths rather than deficits, with the inclusion of psychosocial supports, alongside care coordination and psychological interventions). The aim is to empower individuals to achieve an optimal state of personal, social and emotional wellbeing, recognising that this will result in the best outcome for people with severe mental illness.

4.4.2 INTENSIVE CASE MANAGEMENT MODELS

Assertive Community Treatment is effective in delivering care coordination in severe mental illness models.

Assertive Community Treatment (ACT), also known as intensive case management, is an approach to effectively assist people with severe mental illness with comprehensive ongoing support in health, housing, social connection and safety. These models have a strong evidence base in the context of severe mental illness (at a meta-analysis level), particularly in co-occurring homelessness and mental illness.[xl] ACT is also referred to as 'wrap-around' or fully integrated care. Key elements of ACT models include:

- Person-centred and individualised intensive case management
- Generally longer-term management
- Focus on community integration and living skills.

Models for young people at risk or with severe mental illness should be designed and delivered through a 'youth lens'.

- Focus on co-design of services, early intervention, and trauma-informed care. Designing and delivering services through a 'youth lens' should put young people at the centre of decision-making around their care.[xli]
- Services need to ensure young people have access to broader support services with appropriate linkages, such as employment and education services.[xlii]

4.4.3 PSYCHOSOCIAL SUPPORTS IN SEVERE MENTAL ILLNESS

Models encompassing psychosocial supports are important in severe and complex mental illness, particularly for individuals who are ineligible for the NDIS.

Psychosocial supports are non-clinical interventions aiming to support individuals with mental illness to participate in daily tasks, undertake work or study, find housing, make social connections and involvement in activities and community life. Supports should be person-centred and recovery-focused, based on individual needs. Three essential aspects of psychosocial support have been outlined through University of Melbourne research; support recovery, choice and control, and evidence-based support.[xliii] As identified in Commonwealth Psychosocial Support Guidance, models involving psychosocial supports can be delivered in several ways including through individual support, place-based services, group activities and outreach support.[xliv]

Social prescribing models are emerging in primary care contexts. 'Social prescribing' is increasingly receiving attention in primary health contexts, whereby clinicians 'prescribe' non-medical services or activities to individuals to help improve their physical and mental health. The evidence base for social prescribing is still emerging and currently lags practice.[xlv]

4.4.4 PEER-LED MODELS IN SEVERE MENTAL ILLNESS

Peer-led models have been consistently highlighted in mental health commissions within the context of severe mental illness.

Peer models involve people with lived experience working in paid or voluntary roles playing a key role in supporting individuals with severe mental illness. A recent evidence review outlined that peer workers are key as they foster a sense of safety, community, and security, demonstrating to individuals that they understand their experiences, and that recovery is possible.[xlvi] A recent UK randomised controlled trial found people involved in a peer support program following an acute care admission were significantly less likely to be readmitted to hospital.[xlvii]

4.4.5 OTHER MODELS IN SEVERE MENTAL ILLNESS

Several further well-described models exist in severe and complex mental illness, including police and mental health liaison teams, and Step Up Step Down models. The Sax Institute's review of severe and enduring mental illness models provides comprehensive details of other models for further reference.[xlviii]

Step Up Step Down Service models

Step Up Step Down services models provide community residential mental health intervention on a short-term basis, with the aim of providing care for people either as a 'step up' from non-residential community care (as an alternative to acute inpatient units), or as a 'step down' from an acute inpatient unit. The model combines specialist mental health assessment and treatment with coordinated, recovery-oriented treatment and support. There is a holistic focus on 'personal recovery' as well as clinical recovery, retaining connection with community life, whilst being able to access safe accommodation and on-site mental health support. Step up step down services can also be delivered in an individual's home rather than through staffed residential facilities.

4.5 MODELS IN ALCOHOL AND OTHER DRUGS

4.5.1 OVERVIEW

The table below outlines key models of care in AOD, with dual diagnosis integrated models consistently highlighted as best practice. A key element across models is to ensure every effort is made to support access to services for individuals.

Summary of Findings: Models in Alcohol & Other Drugs		
Key common elements: • Models should ensure a 'no wrong door' approach: ensuring the right support for AOD regardless of entry point into the system • Include the ability to self-refer to services (as well as professional referral)		
Key models		
Dual diagnosis models	Co-located models	Other models
Key findings: • Dual diagnosis integrated models are evidence-based and widely recommended	**Key findings:** • Co-location models can enhance and support the effectiveness of dual diagnosis integrated models	**Key findings:** • Several other models exist, including shared care, sequential care and parallel care

4.5.2 DUAL DIAGNOSIS MODELS

Dual diagnosis models where mental health and AOD management are integrated are effective in AOD.

In recognition of the high prevalence of mental illness and AOD misuse, dual diagnosis models focus on the interaction, and assessment, diagnosis and treatment services across mental illness and AOD. Co-occurring mental health and AOD issues are common, with as many as 75% of people who access mental health treatment and up to 85% of people who access AOD treatment experiencing both disorders.[xlix]

Integrated dual diagnosis models are generally considered best practice in Australia.[l] The evidence base has been classified as moderate to strong in previous evidence reviews, with the inclusion of several RCTs.[li] Dual diagnosis models have been associated with significant reductions in AOD use, hospitalisations, recidivism in the justice system, homelessness, and improved overall life functioning.[lii] Key elements of an integrated model of care for people with co-occurring mental illness and substance abuse were highlighted through the Royal Commission into Victoria's Mental Health System:[liii]

- Welcoming, hopeful, timely and coordinated response
- Simplicity and continuity are prioritised
- Provides choice and control, with simultaneous responses to both co-occurring needs
- Provides support for people who may not wish some, or all available aspects of treatment, care and support.

4.5.3 CO-LOCATED MODELS

Service models often incorporate co-location of services. Co-location of services is outlined in the Final Report of the Royal Commission into Victoria's Mental Health System as one way to build capability to deliver integrated treatment, care and support in AOD management. Enablers and critical components in a co-located model include:[liv]

- Regular case conferencing
- Shared records
- Care coordination
- Shared information systems
- Both service providers working towards joint care goals.

Service models should work towards a unified 'front door' and 'no wrong door' approach, accepting both professional referrals and self-referrals.

A 2015 NSW review of co-morbid mental illness and illicit substance care models use identified several core minimum features of effective models:[lv]

- Mental health practitioners/services conduct universal screening, a thorough risk assessment, and collection of rudimentary diagnosis of the symptoms
- Provide a range of supportive therapies (motivational interviewing, CBT, withdrawal management, medications), prevention and psychoeducation regarding substance use
- Involve AOD services/GPs where appropriate
- Policies and procedures should be in place for assertive follow up
- Services should serve as the primary care coordinator until such time as an alternative service accepts a client.

5. UPSTREAM PREVENTION APPROACHES

5.1 OVERVIEW

Good mental health is inextricably linked to our social, cultural, political, and economic environments. The social determinants of health, endorsed by the World Health Organisation (WHO), provide a framework for understanding the complex interaction of mental health and many other aspects, and the multiple drivers that influence mental health. These drivers should be considered across any aspect of mental health approaches, but are particularly useful to consider in preventative, 'upstream' approaches (see figure 3).

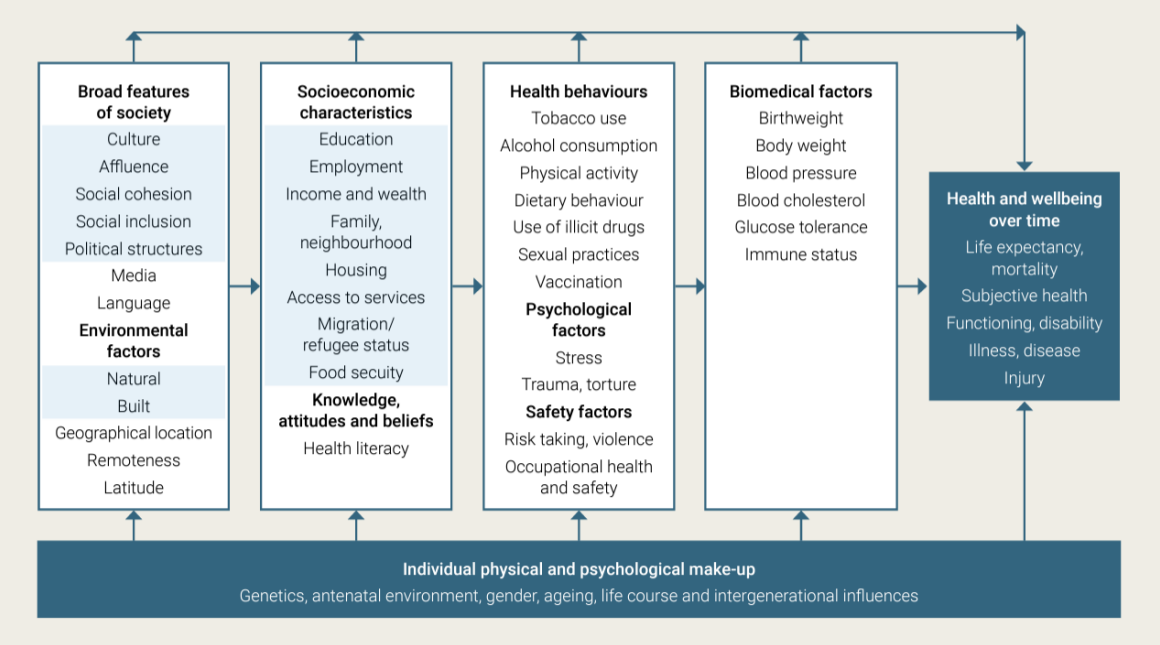

Figure 3 - Framework for determinants of health, AIHW 2018

Summary of findings: Upstream prevention approaches		
Key common elements: • Address underlying risk factors and protective factors for mental health • Approaches are evidence-based, effective and cost-effective		
Key approaches		
Place-based approaches	Approaches to improve social isolation	Youth approaches
Key findings: • Strong evidence base in mental health and AOD use • PHNs most commonly involved in suicide prevention place-based approaches • PHNs are less involved in place-based prevention beyond suicide prevention	**Key findings:** • Strong evidence base in older adults to improve loneliness and isolation, key risk factors for depression • Effective face to face educational and digital models exist •	**Key findings:** • Strong evidence for reducing risk of depression and anxiety in children and adolescents • School approaches are increasingly common with PHN involvement

5.2 PLACE-BASED APPROACHES

Place-based approaches to mental health prevention recognise that the places where people live and spend their time affect their wellbeing. Approaches work in a highly collaborative way with multiple partners and are holistic.

5.3 APPROACHES TO IMPROVE SOCIAL CONNECTION

Social cohesion and connectedness are recognised in the literature for the fundamental role they play in mental health and wellbeing, and are important 'upstream' preventative approaches.

Approaches in older people have been found to be effective, through educational interventions and e-health interventions to reduce social isolation and loneliness.[lvi] Loneliness and social isolation are important risk factors for the development of depression. Higher levels of loneliness have been significantly associated with suicidal ideation and suicide attempts. Furthermore, lonely adults use more healthcare services compared with those that are not lonely.[lvii]

5.4 YOUTH APPROACHES

There is strong evidence through a range of high-quality systematic reviews to demonstrate that preventative approaches can have significant effects in reducing anxiety, depression and internalising symptoms and disorders in children and adolescents. These preventative approaches are not only effective, but also significantly cost effective.[lviii] Approaches are delivered in many contexts, often in school settings given the universality of access.

School approaches

Education environments can be the first point of contact for people who may not have any interaction with the mental health care system. Equipping these environments with knowledge on early warning signs, appropriate referral pathways and the support required to enable recovery is critical.

School approaches should include anti-stigma and anti-bullying programs and aim to assist schools in supporting students' mental health and wellbeing.[lix] These components have been highlighted as key prevention angles in the National Mental Health Commission's 'Best Buys' work with Deakin Health

6. SUMMARY OF FINDINGS

Stepped care is a widely adopted approach in mental health systems, aiming to tailor treatment and support based on the individual's level of need. It is recognised as an evidence-based, staged system, and its effectiveness is widely acknowledged in both Australia and international contexts. To enhance the effectiveness of stepped care, critical enablers need to be integrated throughout the entire system.

In regions with limited access to mental health services, such as rural and remote areas, other approaches like the hub and spoke system can enhance the effectiveness of stepped care.

Within the implementation of system approaches, evidence-based models of care and their key elements provide a base to consider the development of new, locally tailored models in the CCQ region.

For **mild to moderate mental illness**, low-intensity options should be strengthened within care models, and pathways to access these options should be straightforward, without the need for formal referrals. Embedding the key principles of collaborative and integrated models become increasingly important across the care

spectrum, such as relationships and service knowledge, communication, a gentle and flexible service environment and service navigation.

Crisis care and suicide prevention models should be tailored to local needs, involving partnerships across primary health, local hospital networks, and other local organisations. These models may include trained peer workers alongside access to mental health professionals and alternative care settings to emergency departments.

For **severe and complex mental illness**, care coordination alongside psychological services is essential, linking with psychosocial support and emphasising strengths-based and recovery-oriented approaches. Peer-led models have been increasingly supported in severe mental illness contexts. Youth-focused, evidence-based elements are crucial in models designed for young people with severe mental illness. Emerging models are embedding social prescribing for psychosocial support in severe mental illness, although the evidence base is still developing.

In **models for AOD management**, dual diagnosis models that integrate mental health and substance use services are considered best practice, providing comprehensive support through various therapies and interventions. Co-location of services in substance use can improve outcomes, but careful model design is necessary. It is essential to work towards a 'no-wrong door' approach across the care spectrum, ensuring individuals who can benefit from AOD services can access support regardless of their entry point into the system.

Lastly, several evidence-based preventative approaches exist to influence risk factors and protective factors for mental health. Although there is limited literature regarding the implementation of these approaches by PHNs or similar, three relevant evidence-based approaches include place-based approaches, approaches to reduce social isolation, and youth-focused initiatives. These approaches demonstrate an upstream approach to mental health investment to improve community wellbeing in an effective and cost-effective way.

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