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Stepped care in mental health service planning

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Overview

- What is Stepped Care?
- What does Stepped Care mean
  - For Consumers and Carers?
  - For Service providers?
  - For Service planning?
- Why is Stepped Care a good thing and what does it achieve?
- How does regional planning fit into a stepped care framework?
- What are the challenges for implementing stepped care in this region?

What is Stepped Care?

"Evidence-based staged system comprising a hierarchy of interventions, from the least to most intensive, where services are matched to need"

- Origins in physical health care
- Evolution in mental health services for depression
- Uptake in UK and Netherlands
- National Mental Health Commission report recommendation 2015

Key principles of stepped care

- People experience mental illness at different levels of severity
- Evidence-based treatment available at different levels of intensity

- People should enter treatment at lowest level of care likely to be effective
- Progress to higher or lower levels of treatment intensity according to need
- Availability of low intensity options increases early access to treatment and improves outcomes
- System efficiency maximised when resources targeted to level of need

- Severity – not just about diagnosis
- Treatment intensity – considers resource costs and impact on consumer

Comparison to usual care

- Matched care – referred to service provider appropriate to problem
  - problem needs to be correctly identified
  - Service provider needs to be aware of all options
  - Options need to be available
  - New service provider needs to refer back if referral not appropriate or treatment unsuccessful

- In practice
  - MH issue may be missed or ignored
  - “Usual care” applies with limited range of options, not always evidence-based or appropriately targeted
  - No intervention may be offered until problem severe
  - Patient remains with service provider even when not best fit
  - Softening of target groups for services over time

How stepped care works for an individual

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Stepped care as a system

Majority start in lowest levels of care

Significant proportion have needs met

Some progress to next level

Smaller number start with moderate intensity

Most have needs met but some progress to high intensity services

Reduce intensity when sufficient improvement and needs reduced

Smallest number enter at intensive service or moved up from moderate level

Remain at this level until needs substantially reduced

Return to lower levels when appropriate

Key components required for stepped care

- Spectrum of evidence-based services from least to most intensive
- Mechanisms for matching individual need to service level and intensity
- Processes for monitoring progress and adjusting level according to need
- Clear pathways for moving between services providers and levels
- Capacity to monitor system as a whole

What does it mean for consumers and carers?

- Improved access to the right care at the right time
- Earlier access to treatment for lower levels of need
- Better tailoring of care to need through regular assessment and monitoring of progress
- Improved outcomes from evidence-based interventions
- Better integration and coordination across providers
- Some restriction of treatment options, but
- Individual choice should be supported

What does it mean for service providers?

- Better definition of spectrum of services across levels of intensity and severity
- Clarity re position in spectrum and role in system
- Focus on directing individuals to lowest intensity intervention appropriate
- Availability of standardised tools for assessing need and monitoring progress
- Protocols decision making support consistency in services delivered
- Increased focus on pathways, collaboration and information sharing
- Increased oversight and accountability

What does it mean for service planners?

- Planning based on profile of needs for identified population
- Services available to cover full spectrum of severity from least to most intensive
- Monitoring of service utilisation to ensure appropriate patterns of access by needs groups
- Capacity to adjust resource allocations to reflect population needs and improve outcomes and efficiency

What can stepped care provide?

Improved ***outcomes*** for service users

- Earlier access reduces escalation in severity
- Improved tailoring of intervention to individual need
- Ongoing focus on progress and recovery
- Reduces reliance on “treatment as usual”

Improved ***efficiency*** in use of limited resources

- Intensity of intervention matches severity of need
- Low intensity services at lower cost where possible
- High intensity options only provided where required

Improved ***effectiveness*** of services provided

- Focus on delivery of evidence based interventions
- Progress actively monitored and treatment adjusted as required
- Better coordination and integration across providers

How do we align regional planning and stepped care?

1. Identify what services required to meet community needs:

- ✓ Cover full spectrum from low intensity interventions for people at risk high intensity services for people with severe mental illness
- ✓ Include all providers – primary, secondary and community sector
- ✓ Consider access and outcomes for key population groups
- ✓ Identify gaps and overlaps
- ✓ Identify opportunities to rebalance through commissioning or redistribution of resources
- ✓ Monitor and adjust service mix to population needs over time

Aligning regional planning with stepped care

2. Identify what is required for services to function as a stepped care system

? Mechanisms for matching individuals to interventions – assessment of need, monitoring progress and adjusting level
? Pathways into and between levels of intervention
? Changes to practice and culture within existing services
? Support individual consumer choice and provider confidence
? Governance processes for oversight and monitoring of service provision and resource use

1. Identify services required to meet community needs

Define what services and how much of each service are required

Need to know:

- How many people are expected to have mental health treatment needs at different levels of severity?
- How many are likely to seek or need treatment?
- What interventions/services will they require?
- What is currently available, where are the gaps and overlaps?

Population estimates of prevalence:

Severity		Prevalence %
Early signs	Symptoms or distress but do not meet criteria for formal diagnosis	23.1
Mild	Diagnosable symptoms with low impact on functioning, less than 12 months duration	9.1
Moderate	More intense symptoms &/or duration >12 months, some impact on normal roles /functioning	4.6
Severe	Diagnosis and level of impairment – includes all psychoses and some severe depression and other disorders. Can be episodic or persistent; or have complex multiagency needs	3.1

- Also consider relevant indicators as per PHN Needs Assessment:
- Aboriginal and Torres Strait Islander peoples
- Socioeconomic factors

Estimates of service demand:

- Not all people with mental health needs seek or need treatment
- Demand not always linked to severity as defined in planning
- Individual preferences and choice significant
- Expectation that all people with severe disorders receive treatment

Severity	Prevalence	Target %	Treatment %
Early signs	23.1	26	6
Mild	9.1	50	4.5
Moderate	4.6	80	3.7
Severe	3.1	100	3.1

What interventions or services will they require?

Levels of severity	UK Stepped Care model	UK recommended interventions
Severe mental illness Episodic or persistent May have complex multiagency needs	**Step 4**: Services for severe and complex mental health needs	**High intensity treatment including pharmacotherapy and/or psychological therapies** **Inpatient care for some** **Psychosocial support**
Moderate mental illness	**Step 3:** High intensity mental services	**Specialist psychiatrist input** **Pharmacotherapy** **Intensive psychological therapies**
Mild mental illness	**Step 2:** Low intensity mental health services	**Brief psychological therapies** **Structured interventions by trained workers** **Guided digital therapies (clinician and non-clinician)**
At Risk Early signs and symptoms Relapse prevention	**Step 1:** Identification, assessment and active monitoring	**Guided digital therapies** **Unguided digital interventions** **Self-help** **Information and education** **Watchful waiting**

National Mental Health Service Planning Framework – Australia						
Intervention type	**Early Intervention/ Relapse prevention**	**Mild**	**Moderate**		**Severe**	
			Less complex	**More complex**	**Less complex**	**More complex**
Integrated physical health care by GP			*	*	*	*
Specialist Public MHS Community and bed based						*
Individual community support and rehabilitation					*	*
Mental Health Nurse in primary care					*	
Specialist Private MH outpatient & inpatient			*	*	*	
Primary Mental Health Better Access, ATAPS	*	*	*	*	*	
Low intensity Guided self-help, coaching	*	*				
Digital MH Clinician moderated iCBT	*	*	*			

Digital mental health interventions

Wide range of offerings:

- Web based information and resources
- Self-assessment and self-help programs
- Clinician guided interventions using standard modules
- Clinician contact – real time or asynchronous; email to webcam; little to intensive.

Outcomes:

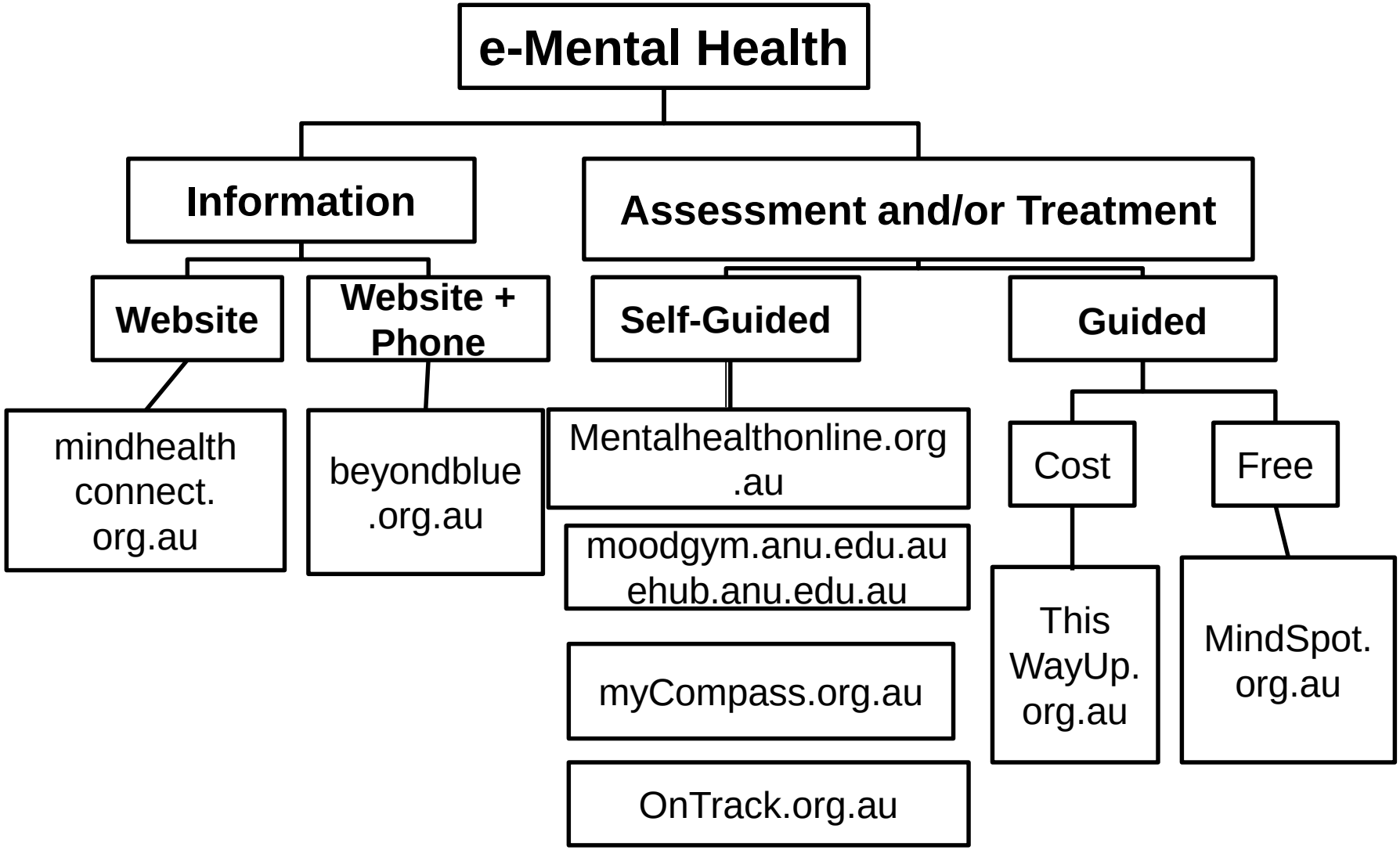
- Evidence that clinician guided iCBT as effective as face-to-face CBT for mild to moderate anxiety and depression
- Better retention and outcomes for clinician guided than unguided interventions
- Shown to be cost effective in both guided and unguided modes
- Challenge to distinguish evidence based interventions

Target group:

- At risk, mild and moderate disorders

Digital interventions: Taxonomy and Examples

(N. Titov, 2016)



Low intensity interventions

Target group: At risk and mild problems

Low intensity in terms of:

- Reduced contact time between the practitioner and consumer (e.g. group therapy, shorter or fewer sessions, supporting use of self-help)
- Delivered by trained practitioners instead of registered health professions
- Uses modified therapy format - content is more simple, brief, less intense, and accessible
- Delivering content in flexible forms to maximise opportunity for service user choice
- Typically accessible via self-referral.

Low intensity CBT:

- UK model Increasing Access to Psychological Therapies (IAPT) level 2
- Australia – *beyondblue* NewAccess pilot - coaches

Higher intensity interventions

Target Group: moderate disorders – 4.5% of population

Example:

- Better Access structured psychological services
- ATAPS / MHSRRA

- Individualised therapy delivered by registered health professional
- Increased clinician/client contact
- Typically delivered face-to-face but can include other modalities
- More focused and intensive = higher cost
- Resource limitations may impact on access

Specialised interventions for severe disorders

Target group: Severe disorders - 3.5% of population
Severe & persistent - 1.1%
Severe, persistent & complex – 0.4%

Examples:

- Inpatient care – private and public
- Public sector mental health services
- Mental health nurses in primary care - MHNIP
- NGO delivered individualised support – PIR / NDIS
- Integrated physical and mental health care

What services are currently available and how do they align with what is required?

Map local services against profile to identify gaps and unknowns

- Which providers available, what are they delivering, at what capacity?
- How do these match identified needs groups – are services getting to the right people?
- Are there gaps in the spectrum of services available?
- How do gaps impact on other services?

What are the likely service gaps?

New service types:

- Digital or E-mental health services
- Low intensity interventions

Primary mental health services:

- General practitioners
- Individual psychological therapies

Specialised mental health treatment services:

- Integrated care for people with severe illness and complex needs

2. What is required to help current services work as a stepped care system?

- Mechanisms for matching individuals to appropriate interventions
- Processes for sharing information for care planning and coordination
- Clinical governance and risk management processes
- Processes for monitoring system performance
- Commitment of stakeholders

Working as a stepped care system

- *Mechanisms for matching individuals to appropriate interventions*

- Triage and assessment tools needed for assessing severity of need on entry and reassessing at set intervals to monitor progress

- Protocols for assigning individuals to available interventions based on assessed level of severity

- Referral mechanisms to link individuals to the appropriate intervention according to assessed need and individual preference

- Protocols for reviewing progress and increasing/decreasing intensity

Working as a stepped care system

➢ *Processes for sharing information for care planning and coordination*

- Stepping up or down risks gaps, discontinuity and poor outcomes
- Lack of communication between providers identified as barrier to implementing stepped care
- Need protocols for sharing sensitive information between providers including consent and privacy protection
- Record keeping practices and capability variable
- Technology solutions available that facilitate care pathways across providers, but costs significant barrier

Working as a stepped care system

- *Clinical governance and risk management processes*

- Processes for assessing individual clinical risk are critical, particularly in low intensity services

- Reliance on automated measures may not be sufficient

- Risk management processes required for rapid identification and escalation to higher levels of intervention where required

- Ensure appropriate training, supervision and oversight of non-professional workers in low intensity services

Working as a stepped care system

➢ *Processes for monitoring system performance*

- Need central collection and analysis of clinical and administrative data to monitor system performance
- Should include review of patient flows, progress, step up/step down and relapse rates
- Compare patterns in service utilisation to target rates
- Monitor costs – model relies on low intensity services being cost effective

Working as a stepped care system

- *Engagement of stakeholders*

- Critical that stakeholders actively engaged for model to be successful
  - service users, service providers and broader community members
  - aware of range and effectiveness of service options available
  - committed to participation in stepped care processes

- Involves change to established practices which may be resisted by service users and service providers

- Consumer preference and treatment readiness shown to impact on outcomes
- Support choice for consumers – individual variation in how service options are perceived, capacity to utilise and impact of factors such as cost, travel time, internet access etc

Summary – Key questions and challenges

Regional planning:

- Where are mental health needs not being met across spectrum of population need?
- Are existing services targeting the right people?
- What capacity is there to realign existing services and resources towards meeting these gaps?
- Where should new services be targeted?
- What are the barriers that need to be addressed in meeting the needs of particular population groups?

Working as a stepped care system:

- How informed and committed are stakeholders to supporting a stepped care model?
- What can be done to build commitment and engagement?
- How can development of shared processes be progressed (eg for assessment, referral, progress monitoring, information sharing and data collection)?
- What is needed to oversee how services work as a system?