Australian Government

Department of Health, Disability and Ageing

PRIMARY HEALTH NETWORK PRIMARY MENTAL HEALTH CARE PROGRAM GUIDANCE

MENTAL HEALTH MULTIDISCIPLINARY SERVICES FOR PEOPLE WITH COMPLEX MENTAL HEALTH NEEDS IN PRIMARY CARE SETTINGS

1. Introduction

This document provides guidance to Primary Health Networks (PHNs) on multidisciplinary mental health services for people with complex mental health needs.

The Mental Health Multidisciplinary Services Program contributes to the achievement of Program 1.2 Mental Health outcomes and objectives, through delivery of targeted, place-based multidisciplinary services for people with complex mental health needs.

Aligned with the objectives and outcomes of Program 1.2, the desired outcomes of the Mental Health Multidisciplinary Services Program are:

- People with complex mental health needs receive person centred and holistic care, from clinical and non-clinical supports, resulting in a closer alignment between primary care and mental health care.
- People with complex mental health needs experience improvements in mental health resulting from services delivered and receive an improved experience of care.
- People with complex mental health needs see an improvement in access to mental health multidisciplinary services.
- There are fewer service disengagements, hospital admissions and emergency department presentations through successful engagement with multidisciplinary services.
- There is access to mental health workers employed to help support these outcomes.
- There is an uplift in the ability of general practices and Aboriginal Community Controlled Health Organisations (ACCHOs) to ensure ongoing support and continuity of care via multidisciplinary services.

Through the MDT program, PHNs are expected to:

- **Plan, design and commission mental health multidisciplinary service models** which are tailored to work with general practices and ACCHOs to meet local needs within primary care settings in their region. PHNs have flexibility in determining the funding and service models which are most appropriate for their regionally assessed needs and market conditions.
- Support the **employment of additional mental health workers** to provide timely support to people with complex mental health needs, including between General Practitioner (GP) or specialist appointments. **Suitable workforces are determined by PHNs** but may include workers providing both clinical and/or non-clinical supports.
- **Support the ongoing delivery** of high-quality, place-based mental health multidisciplinary services to people with complex mental health needs, at no cost to the participant and for a period of up to 2 years per individual.
- **Contribute, through data collection and evaluation activities**, to an understanding of the factors impacting effective multidisciplinary service design, establishment and commissioning through PHNs.

1.1 Context

A key recommendation from the Evaluation of the Better Access Initiative, conducted in 2022, found alternative models of service delivery should be considered, to complement but not duplicate, the existing services provided through Better Access. Recommendation 1 from the Better Access evaluation stated that for people with complex mental health needs, Better Access should be supplemented by other multidisciplinary models that not only provide more intensive, longer-term clinical care, but also offer holistic support for the individual through a combination of clinical and non-clinical services.

As outlined in the Strengthening Medicare Taskforce Report, Australians seek care from a range of different health professionals across primary care and other care settings, for various reasons including privacy, cultural, and accessibility factors. Connection and collaboration through coordinated multidisciplinary care teams can increase accessibility and engagement with the primary mental health care system, can deliver better outcomes for people, and can assist people with managing their own health.

1.2 What is the Intent of the Mental Health Multidisciplinary Services Program?

The Mental Health Multidisciplinary Services Program (Program) will complement existing clinical treatment services under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access)* initiative and/or other complementary services, including state-based service models. It will serve to support general practices, ACCHOs and the primary care system more broadly to safely manage and support people with complex mental health needs in the community. Multidisciplinary services also seek to reduce pressure on hospitals and the need for people to access more intensive supports through the National Disability Insurance Scheme or state-based community mental health services.

Further intended outcomes of the Program include:

- Development and retention of a larger, more sustainable mental health workforce.
- Reduced wait times and improved accessibility and engagement with services.

What is Multidisciplinary Team-Based Care?

Multidisciplinary team-based care can be defined as ‘professionals from a range of disciplines working together to deliver comprehensive, coordinated and collaborative care that addresses as many of the person’s needs as possible to improve health and wellbeing outcomes.’ This is a person-centred approach which empowers the individual (as well as their family, carers and kin[1]). Multidisciplinary team-based care is well suited for delivering holistic, person-centred mental health care.

Multidisciplinary team-based care can be delivered by a range of professionals functioning as a team under one organisational umbrella, or by professionals from different organisations - including private practice - brought together as a unique team. As a person’s

[1] Mitchell et al. ‘Multidisciplinary care planning and teamwork in primary care’ Medical Journal of Australia, 2008

condition or circumstances changes over time, the composition of the team may change to reflect the changing clinical and non-clinical needs of the person[2].

Traits of multidisciplinary teams may include:

- **Broad and flexible workforces –** the membership of a multidisciplinary team in primary care is flexible and responsive to the unique needs of the people and communities they serve.
- **Integration –** multidisciplinary teams may operate as co-located entities within shared physical locations, or separate entities linked by digital system capabilities and other supports. Co-location can reduce professional isolation, build interprofessional capacity and facilitate comprehensive and coordinated care for people. Digital capabilities and systems aim to overcome geographic limitations to flexibly provide in person and/or telehealth services.
- **Roles –** multidisciplinary team models, especially in mental health care, are directly influenced by the needs of the program participants and populations alongside available regional workforces. Within the mental health multidisciplinary team, a GP plays a key role in initial assessment and triage, as well as ongoing case management. Multidisciplinary teams may be GP-led or led by other health workers, with care coordination involving GPs and program participants as appropriate. Teams should provide support according to individual need and/or based upon local arrangements. For these reasons, models of multidisciplinary team-based care may look and operate differently within or across geographical locations.

2. National Standards for PHN-Commissioned Multidisciplinary Team Services

PHNs have flexibility to commission multidisciplinary services to suit local and regional needs and market conditions, however, services must meet the following minimum program standards:

2.1 Regionally Appropriate Solutions

Multidisciplinary team-based models must be evidence-based, holistic and person-centric, with services tailored to meet identified regional and individual participant needs, as these may change over time. They must be designed to complement, rather than duplicate existing services, and to clearly contribute to the stated outcomes of the Program via regionally appropriate solutions to improved care for eligible people in the community.

2.2 No Program Participant Costs

PHNs must ensure that program participants incur no out-of-pocket costs at any stage of their multidisciplinary health care journey. Multidisciplinary services should seek to appropriately complement other existing service pathways.

All Program services which claim a Medicare benefit must adhere to all general rules and standards of the *Health Insurance Act 1973* (the HIA). Therefore, a Medicare benefit is

[2] ibid, Adapted from Mitchell et al. 2008 MJA

payable to a participant where the HIA does not indicate otherwise, including under subsection 19(2) of the HIA.

Non-health services (e.g., employment, housing etc.,) are out of scope for funding under the Program.

2.3 Program Participant Journey and Profile

Program participants must be assessed as having 'complex mental health needs'. Complex mental health needs are defined as 'people who have a mental illness that has a high impact on their day-to-day lives. They have severe and persistent, or episodic mental ill health and may experience significant social, environmental and physical stressors[3]. Persons with complex mental health needs may experience significant social and environmental stressors and traumas as well as co-occurring physical, mental, emotional, developmental and substance abuse issues.[4]

Eligible program participants will be assessed at Levels 3-5 of the Initial Assessment Referral Decision making tool.

Program participants will be expected to undertake participant-reported outcome measurements (PROM). This will be completed at a minimum, at the commencement and completion of their episodes of care within the Program. PHNs will be required to utilise the Kessler Psychological Distress Scale (mK5/K10+ as suitable) for all participants, as well as a quality-of-life PROM of each PHNs choosing.

Program participants may access the program for up to two years, with no minimum or maximum appointments set. Duration of engagement in the Program will be determined based upon initial clinical assessment in conjunction with regular case reviews. This allows for holistic continuity of care for Program participants across the Program's duration, particularly for individuals who may otherwise be unable to access multidisciplinary services.

People with complex mental health needs often experience co-occurring conditions, which may increase the complexity of care and services required. Consideration should be given to the Stepped Care Model [5]in service design and referral.

Individual participant care plans are to be developed collaboratively between GPs/ACCHO/primary care practitioners and mental health/allied health professionals, with regular case conferencing to occur.

Services may take place face-to-face or via alternative modes of service delivery such as telehealth as appropriate. Decisions about the approach to care delivery should be informed by evidence-based assessments of participant needs.

2.4 Services

Specific services delivered through this Program are tailored to the individual's needs. They may include care coordination and service navigation, case management, brief interventions,

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[3] This definition for severe/and or complex is a modified definition, based off the definition sourced from the National Mental Health Service Planning Framework.

[4] This is a modified and extracted definition sourced from the National Guidelines to Improve Coordination of Treatment and Supports for People with Severe and Complex Mental Illness. National Guidelines to improve coordination of treatment and supports for people with severe and complex mental illness

[5] Primary Mental Health Care Flexible Funding Pool Programme Guidance – Stepped Care 2019

psychosocial support services and social prescribing. PHNs may also look to commission appropriate services beyond those listed above and have the flexibility to determine and commission services as needed.

2.5 Integration with Primary Care

Service design should be appropriately underpinned by collaborative planning and commissioning with Local Hospital Networks or equivalent, community health services and other state or territory aligned mechanisms to ensure integration. Other requirements to help ensure integration over time are:

- Each PHN will have locally designed processes for referral in to and out of the Program, including through the primary GP or ACCHO setting, as well as clearly defined processes for managing program participant journeys, referrals and overall program demand.
- Referral pathways and demand management will be as determined and reviewed by PHNs and participating health care providers. These processes should be informed by co-design and stakeholder consultation and tailored to suit local conditions over time.
- Referral processes must align with the Stepped Care Model[6] requirements and must be suitably integrated with other services, including state-based services.
- There must be distinct boundaries between the new multidisciplinary team-based models implemented by PHNs and any existing or planned multidisciplinary services, to avoid service duplication.

2.6 Workforce Composition for the Mental Health Multidisciplinary Services Program

PHNs have the flexibility to design and implement place-based solutions to meet Program outcomes. This flexibility allows PHNs to determine suitable multidisciplinary team workforces to meet local population needs through clinical and non-clinical services. This also allows flexibility for PHNs to adapt services to manage availability of local workforces as might be required over time.

Eligible workers may include but are not limited to; social workers, occupational therapists, appropriately qualified counsellors and psychotherapists, mental health workers, nurses (including mental health nurses), First Nations practitioners, health workers and/or social and emotional wellbeing workers, and peer/lived experience workers. (collectively referred to as ‘mental health workers’).

Mental Health workers employed under this Program must not be directly employed by PHNs.

Program workers will be expected to submit self-reported outcome and experience measurements, against assessment methods deemed appropriate by PHNs. These may be against established clinician-reported outcome scales. Clinician-based measures of experience, outcomes, and capability will be collected as a component of PHN evaluations and will also be collected through the national program evaluation.

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7. Primary Mental Health Care Flexible Funding Pool Programme Guidance – Stepped Care 2019

2.7 Opportunities for Broader Impact

Broader (non-health care) supports possibly required to address complex mental health challenges are out of direct scope of the Program. However, opportunities for indirect impact via broader collaborative commissioning and planning with other local, state or territory aligned mechanisms should be considered by PHNs where appropriate.

3. Data Collection, Reporting, and Evaluation

Data will be collected to monitor and assess multidisciplinary service provision. Specific reporting requirements will form part of the funded organisation's agreement with the department, as outlined in the funding agreement and other relevant documentation.

Program data collection and reporting must demonstrate PHNs' performance against the below indicators:

Performance Indicators
Number of mental health workers employed in the multi-disciplinary teams
Wait times experienced by referred participant to mental health workers
Program participants attend/receive services
People with complex mental health needs self-report an improvement in their mental health, quality of life and wellbeing following receipt of services

Participant privacy is critical. All data and information collected from Program participants should be provided with strict adherence to privacy/consent requirements. These must be at least equivalent to requirements for Primary Mental Health Care Minimum Data Set (PMHC MDS) data collection, regardless of the mechanism for collection and reporting, as follows:

- it is the responsibility of PHNs, service providers, and the department to ensure participant information is managed appropriately and in accordance with respective obligations under legislation and the Australian Privacy Principles.
- all entered data are communicated and stored in compliance with Australian privacy and data security legislation. This includes encrypting all information in transit and ensuring that only appropriate and approved people have access to that information.

Each PHN funded under this Program will undertake an independent evaluation. Each individual PHN-led evaluation will also seek to complement a national, program-level evaluation to be undertaken by the department.

4. Useful Resources

4.1 Models of Multidisciplinary Services

PHNs are encouraged to examine available evidence and resource materials on multidisciplinary team-based models, especially within the primary mental health care space, which have been implemented both in Australia and internationally.

Some examples of multidisciplinary service models include the following:

- Primary Care Behavioural Health (PCBH) Model – USA
    - The Primary Care Behavioural Health Model is an integrated care approach that embeds behavioural health consultants (BHCs) within a primary care setting and receives the benefits of co-location.
    - BHCs are clinicians (social workers, registered nurses, psychologists, occupational therapists etc.) who provide brief, targeted evidence-based interventions to identified patients for a range of issues, including mental health treatments.
    - BHCs typically receive patients on an immediate/same-day timeframe, allowing for efficient collaboration between the GP and the mental health practitioner. This model allows for enhanced collaboration between practitioners, clinicians, and all clinic staff to provide coordinated, team-based care.
- Collaborative Care Model (COCM) – USA
    - The Collaborative Care model is an evidence-supported model which has proven useful to providing psychosocial and medication treatments. Embedded BHCMs (Behavioural Health Care Managers) in primary care practices are at the heart of the collaborative team, facilitating communications and care on the patient's behalf, supporting the GP by coordinating an overall treatment plan, providing brief psychological therapies which are primary-care appropriate, and supporting medication management. BHCMs are typically social workers, mental health nurses, or psychologists.
    - This model features an external psychiatric consultant, who supports treatment offered by both the GP and the BHCM in treating patients with behavioural health issues. The psychiatric consultant will assist the team with treatment planning and suggest recommendations about changes in treatment when the patient is experiencing chronic lack of improvement.
    - The CCOM has led to improved mental health outcomes, prescribing outcomes, and patient satisfaction, alongside improved escalation and referral processes. It may be delivered remotely but is typically co-located within a general practice.
- Integrated Primary Mental Health and Addiction Service (IPMHA) Model – New Zealand
    - The IPMHA model, a composite integrated service model, is a co-located team service model which demonstrates the integrated relationships between various practitioner types in a primary care setting. In a co-located practice setting, GPs will refer to other team members within the teamlet.
    - A team consists of a GP, a health improvement practitioner (an experienced mental health clinician), a health coach (a trained support, peer or cultural

worker who provides psychosocial, non-clinical supports), and a support link worker (who provides links to further social/cultural supports in the broader community).
    - This model has led to high levels of patient satisfaction and priority population engagement, especially with First nations peoples. It has increased overall engagement and accessibility and has successfully been implemented across New Zealand.
- FACT (Flexible Assertive Community Treatment) – Netherlands
    - FACT is a form of mental health care that provides integrated, community-based treatment for individuals with severe mental ill health. It is an adaptation of the Assertive Community Treatment (ACT) model, developed in the US, with a key distinction being its improved escalation and de-escalation processes for patient care, to refer patients as necessary across stepped care.
    - FACT is delivered via multidisciplinary team care, with teams typically consisting of a psychiatrists, psychologists, social workers, mental health nurses, peer workers, and other appropriate workers. Teams are based out of community mental health centres, not general practices, but are closely integrated and linked with GPs and primary care providers. Teams share and manage individual cases collaboratively to prioritise person-focused care.
    - FACT has been proven effective, especially for treatment of addiction and for treating specific sub-populations such as youth. The model has shown positive results, has led to a reduction in hospital admissions and improved continuity of care. FACT has been replicated and implemented in other countries, including Belgium, Sweden, and the United Kingdom.