Primary mental health services for young people with, or at risk of, severe and complex mental illness

Commissioning Intentions Document
Version 1.0
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Primary Health Tasmania

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Primary Health Tasmania Commissioning Intention

Primary Health Tasmania will work with communities and our service provider partners to develop innovative service models for primary mental health services for young people with, or at risk of, severe and complex mental illness.

Our commissioning process aims to:

1. understand service priorities for the Tasmanian community;

2. determine agreed priorities and identify the targeted service solutions and associated performance criteria that Primary Health Tasmania can implement to contribute to improved health and well-being outcomes;

3. implement new primary mental health services from February 2017 – 30 June 2018; and

4. Build the capacity of the primary mental health service sector.
Executive Summary

Within Tasmania, the Australian Government has allocated the role of commissioning primary health mental health services for young people with, or at risk of severe and complex mental illness to Primary Health Tasmania. Our aim is to work collaboratively with the sector to improve coordination of care as well as the efficiency and effectiveness of service delivery.

As part of the needs assessment and design stages of the commissioning cycle Primary Health Tasmania has:

- consulted extensively with the mental health sector and other key stakeholders;
- undertaken a comprehensive needs assessment by analysing available data; and
- reviewed service models.

As part of the commissioning cycle Primary Health Tasmania gathered information about the range of current service models within Australia and internationally.

As part of the commissioning cycle information about service gaps and priorities was also gathered from multiple perspectives including:

- private and government clinical service providers;
- the Tasmanian Government Department of Health and Human Services;
- community support organisations; and
- peak bodies, including consumer and carer representatives.

Key service design recommendations that emerged from consultations included:

- a reorientation of services towards symptom management rather than crisis management;
- a collaborative and coordinated service model that is flexible and adaptive to consumer needs and provides seamless transitions between service components;
- a community approach to address stigma and improve mental health literacy; and
- improved access to youth-friendly services with outreach to support isolated communities and 24-hour support.

Because of the needs assessment and priority setting Primary Health Tasmanian has determined the following primary mental health service commissioning intentions

- case management services that include wrap-around care and brief psychological interventions;
- specialist psychological interventions;
- workforce development activities to support the primary mental health care workforce.
What is commissioning?

At its simplest, commissioning means planning and buying services to meet the health needs of local populations. It involves understanding localised priority issues and procuring appropriate services to address those issues in the most effective and efficient manner. Commissioning is different to the way we have been purchasing health and community services in the past; with a strong focus on ensuring outcomes for communities and populations, rather than a focus on delivering activity.

As well as planning and procuring, our commissioning model involves a continuous cycle of engagement and collaboration with communities, service providers and other stakeholders to ensure fit-for-purpose services and initiatives are designed and delivered to improve the health and well-being of Tasmanians.

Primary Health Tasmania’s commissioning model involves four phases in a cyclical process:

1. **Assessing Needs** – understanding what local communities need and working out the local priorities we can address based on this information:

2. **Designing Solutions** – working with others to identify the most efficient and effective ways we can address the identified priorities

3. **Implementing Solutions** – procuring quality health services and initiatives and proactively working with providers to monitor performance and progress towards agreed outcomes

4. **Evaluating Outcomes** – assessing the efficiency and effectiveness of services and initiatives (including value for both health gains and money) against outcomes and informing priorities for future investment in successive commissioning cycles.

While described as four phases, the commissioning cycle is a fluid process, requiring consideration of all elements of commissioning through each phase of the cycle. For example, during the assessing needs phase, measuring and evaluating outcomes needs to be considered early as part of understanding the priority needs and identifying what we want to change. The design and implementing solutions phases then need to lead to measurable and achievable outcomes.

Engagement and collaboration with partners is essential to ensure improved health and well-being outcomes in Tasmania.
What is the purpose of this document?

The Australian Government Department of Health has contracted Primary Health Tasmania to commission services within Tasmania. Accordingly, the purpose of this document is to outline the commissioning process Primary Health Tasmania will undertake to inform its investment in primary mental health services for young people with, or at risk of, severe and complex mental illness through to June 2018. This document describes the commissioning cycle, including the approach the organisation will take and the information we will gather to inform service and sector capacity building commissioning.

This commissioning intentions document is a key resource to ensure we work with local stakeholders to develop a shared understanding of the priority issues to be addressed for Tasmania. It outlines the outcomes of data analysis and consultations to inform priorities for service design.

This is a 'living' document that we will continue to update as we move through the commissioning cycle, from understanding the needs and priorities to be addressed, designing and implementing the solutions to evaluating the outcomes. Consequently, you will note that Phases 3 and 4 in the cycle will be completed as we move through the commissioning process.

As we complete each phase of this process, this document will be made available on our website for all stakeholders to access.

The objectives of Primary Health Tasmania have been established by the Australian Government as:

- to increase the efficiency and effectiveness of medical services for patients - particularly those at risk of poor health outcomes; and
- to improve the coordination of care to ensure patients receive the right care in the right place at the right time

As part of this focus, Primary Health Tasmania will use a commissioning approach to prioritise investment in the Primary health mental health sector. Commissioning moves beyond the current system of simple service contracting and purchasing to more targeted and measured approaches to care. This approach is required to deliver a greater focus on the outcomes we aim to achieve through investment rather than on activity alone. This will assist us to:

- determine how Primary Health Tasmania will directly target resources for primary health care services to address priority health needs; and
- develop quality key performance indicators to ensure all services and initiatives commissioned by Primary Health Tasmania include a focus on access to high quality primary health services for young people with or at risk of, severe mental illness.

The Australian Government is funding the 31 Primary Health Networks (PHNs) around Australia – including Primary Health Tasmania – to commission mental health services to meet local needs.

Australian Government-funded community-based mental health services are currently delivered by a range of organisations and individual providers around the state. The Australian Government has decided that over a three-year phasing-in period starting 1 July 2016, PHNs
will move to eventually commission all regionally-delivered Australian Government primary mental health programs.

All PHNs will plan and commission services for:

- Aboriginal and Torres Strait Islander people with mental illness;
- people with mild mental illness;
- people with mild to moderate mental illness;
- people with severe and complex mental illness; and
- suicide prevention.

PHNs now contract local headspace youth mental health services, which were previously managed directly by the Australian Government Department of Health through the national headspace office. PHNs also contract short-term psychological services for rural and remote, underserviced and hard to reach groups (the program formerly known as Access to Allied Psychological Services - ATAPS) and contract general practices under the Mental Health Nursing Incentive Program. Primary health networks are also responsibility for managing contracts for community based suicide prevention activities.

Primary Health Tasmania is one of 10 PHNs chosen to take a lead role in developing and delivering new models of primary mental health care. Tasmania’s focus is care for young people with severe and complex mental illness.

This work builds on the core role of PHNs in improving integration and coordination of care, and increasing the effectiveness and efficiency of services so people receive the right care in the right place at the right time. This will be assisted by working with system partners to develop a stepped model of care that is right for Tasmania.

1.1 What are we commissioning?

Primary Health Tasmania is developing and commissioning innovative models of service delivery to meet the needs of young people with, or at risk of, severe mental health illness who can be appropriately managed in the primary care setting.

The following themes have emerged as important components of good services:

- case management and coordination of care;
- cross-sectoral collaboration to ensure strong links with community support organisations;
- team-based care that makes use of the skills of a range of professionals;
- person-centred care.

Considerations will include the differences in the needs of young people, and the relevant skills and appropriate service delivery models to meet these needs. A range of models may be needed to address the diverse clinical needs of young people with severe mental illness, as a one size fits all approach is unlikely to be appropriate. There is likely to be a need to match the intensity and mix of services to the degree of need of the young person.
Commissioning timeframes

The first commissioning cycle will be from July 2016 – June 2018, in line with initial funding timeframes set by the Australian Government for the Primary Health Tasmania.

Assessing Needs
Aug – Oct 2016
- Youth mental health needs assessment completed
- Service mapping completed
- Literature review completed
- Youth mental health priorities and system issues determined

Designing Solutions
Sep – Nov 2016
- Stakeholder consultation and engagement about priority needs and service system issues undertaken
- Analysis of stakeholder feedback
- Agreement on priorities to be commissioned
- Commissioning KPIs specifications developed

Implementing Solutions
Nov 2016 – Feb 2017
- Procurement process undertaken (e.g. tender)
- Assessment of applications completed
- Decisions communicated to providers
- New service agreement established
- Services ready for commencement in February 2017

Evaluating Outcomes
Feb 2017 – Jun 2018
- Build service provider understanding of outcomes based measures
- Monitor and evaluate client and service outcomes
- Create a shared understanding of what has and what hasn’t worked and provide recommendations for future action

Who will we work with?

Stakeholder engagement is a critical element for each phase of the commissioning cycle. Primary Health Tasmania has undertaken a stakeholder analysis and identification to ensure that people interested in primary mental health services for young people with or at risk of, severe and complex mental illness commissioning can be informed and engaged during the commissioning process.

Evaluating our approach

As commissioning is a relatively new concept for the Australian health system and for Primary Health Tasmania, it is important that the commissioning cycle is evaluated as part of a continuous quality improvement process for the organisation and to ensure that we are achieving the desired results. We will evaluate the commissioning cycle to understand:

- if we are undertaking the process in the best way possible;
- how we can improve processes to make it easier for providers over time;
- how we can assess and respond to changes in health and well-being outcomes; and
- if we are engaging with our stakeholders in a meaningful and effective way.
PHASE 1 – ASSESSING NEEDS

Defining the primary mental health services to be commissioned for young people with, or at risk of, severe and complex mental illness

Understanding the context + Understanding priority needs + Understanding the service systems + Understanding how things can be different
1. Understanding young people’s mental health in Tasmania

Data specific to youth mental health in Tasmania is limited. The 2013-2014 Australian Child and Adolescent Survey of Mental Health and Wellbeing (known as the Young Minds Matter Survey) explores the prevalence of mental health disorders in children and adolescents across Australia. It surveyed households with children aged 4–17, and examined their health behaviours and use of mental health services. The National Survey of Mental Health and Wellbeing includes young people aged 16-25. This survey explores the prevalence of mental health disorders among adults in Australia.

Data from these surveys has been used to inform what we know about young people’s mental health in Tasmania.

1.1 Prevalence of mental health disorders

Most children and adolescents have good mental health, however, 1 in 7 (14%) report having a mental health disorder.

- The prevalence of mental health disorders is higher in males (16%) than females (12%) across all disorders (except major depressive disorder).
- Attention deficit hyperactivity disorder (ADHD) is the most prevalent disorder for males, and anxiety disorders are most prevalent disorder among females.
- 7.7% of children report having major depressive disorder when they reported it themselves. When the information was provided by a parent or carer, the prevalence or major depressive disorder is 4.7%.
- 8.3% of children have ‘mild’ disorders, 3.5% ‘moderate’ and 2.1% ‘severe’ disorders.
- More prevalent conditions such as ADHD and anxiety disorders are more likely to be rated as having mild or moderate impact than severe impact. Major depressive disorder is the only condition in which mild impact is less common than moderate and severe impact.

Most young people aged 16-24 also have good mental health, however, 1 in 4 (26%) report having a mental health disorder.

- The prevalence of mental health disorders is higher in females (30%) than males (23%).
- Substance use disorder is the most prevalent disorder for males (15%), and anxiety disorders are the most prevalent disorders among females (22%).
- Depression is twice as common among females (8%) than males (4%).

1.2 Suicide and self-harm

Suicide is the leading cause of death for Australians aged 15–24, and the rates of suicidal behaviour have remained relatively stable over the last 15 years. In 2015, suicide accounted for one-third of deaths (33.9%) among people 15-24 years of age across Australia. It was the leading cause of death across Australia in the 5-17-year-old category. In the 15-19 year, old age group in 2015, approximately 12 per 100,000 males and 8 per 100,000 females died from intentional self-harm. In the 20-24 year, old age group these figures were 23 and 7 per 100,000, respectively.
The relationship between suicide and self-harm behaviours is strong; 50% of young people who die by suicide had previously engaged in self-harm behaviours.

- 11% of young people aged 12–17 have self-harmed, though this is likely to be higher as 7.5% of survey respondents preferred not to answer questions about self-harm.
- Females aged 16–17 have the highest prevalence of ever having harmed themselves (23%), over 3 times the rate of males the same age.
- Self-harm is most commonly associated with major depressive disorder, with nearly half of all depressed young females having ever self-harmed.
- 11% of young people aged 16-17 have had suicidal thoughts, and 7.8% have made a suicide plan in the last 12 months. Rates of suicidal thoughts are higher in females (15%) than males (6.8%).
- Like self-harm, the strongest association between thoughts of suicide and mental disorders occurs for those with major depressive disorder.

Additional information about suicide and self-harm in young people aged 12-17 is available from the Young Minds Matter survey.

1.3 Mental health service use

The Young Minds Matter Survey showed that around 50% of all 4-17-year-olds with a mental health disorder used mental health services.

- Disorders with more severe impact are associated with more service use; 88% of children with a mental disorder that severely affected their daily lives accessed services, compared with 73% of those with moderate disorders and 41% with mild disorders.
- One in 10 children who receive support for mental health issues do not have a diagnosable mental disorder. 40% of service users have symptoms of a mental disorder, but did not meet the threshold for a ‘mental disorder’.

Equivalent data is not available for those aged 18-24. Overall, it is estimated that 46% of all adults with a mental health disorder used mental health services in 2013.

1.4 Outpatient services

According to the Young Minds Matter Survey, community-based health and school services are the most common types of outpatient services used by 4–17-year-olds.

- Community-based health services including general practice, psychologists, community psychiatrists and community-based mental health teams are common outpatient services.
- The most common school services are individual counselling, followed by group counselling and school nurse services.
- Almost 30% of young people aged 13-17 with a mental disorder access services online. These young people most commonly access information about mental health issues, followed by assessment tools.
- 20% of young people aged 13-17 without a mental disorder also access online services, mostly seeking information about mental health issues.
1.5 Hospital services
There are no dedicated child and adolescent mental health inpatient units in Tasmania. When admission is necessary, it either occurs on paediatric wards or as a special admittance case to adult mental health units.

- Approximately 0.13% of all Tasmanian children and adolescents under 15 are admitted to hospital with a primary mental health diagnosis.
- Across Tasmania in 2013-2014, 34 children and adolescents were admitted in to adult mental health units and 179 were admitted to non-mental health inpatient wards.
- Most children are admitted between the ages of 13 and 18.
- There is some regional variation in contact with hospitals for mental health services (not limited to hospital admission). There is more hospital contact in the north.

1.6 headspace services
- In 2013-2014, 7.4% of Young Minds Matter respondents had accessed one or more of headspace’s services (e.g. accessed online information, spoken to a headspace professional, or visited a headspace site).
- In 2015-2016, 2,722 young people (aged 12-25) accessed headspace services in Tasmania.

1.7 Short-term psychological interventions (formerly ATAPS)
In 2015-16, 494 young people (aged 12-25) accessed short-term psychological intervention services in Tasmania (funded by the Australian Government through Primary Health Networks).

1.8 Medicare-funded services
In 2014-15 in Tasmania, the following Medicare services were used:
- 1,118 young people (aged 12-24) visited a private psychiatrist
- 2,811 young people visited a clinical psychologist
- 2,421 young people visited an allied health professional (psychologist, social worker, occupational therapist)
The regional distribution of young people using Medicare-funded mental services in Tasmania

![MBS mental health item claims per SA3 region & year chart]

- Patients per 1,000 (2014-15)
- Patients per 1,000 (2013-14)
- Patients per 1,000 (2012-13)
- Patients per 1,000 (2011-12)
Number of young people (aged 12-24) for whom MBS mental health items were claimed in 2014-2015 (per 1000 population)

*Includes services provided by GPs, psychiatrists, psychologists and other eligible allied health workers.
2. Evidence-based primary mental health care models

Primary Health Tasmania commissioned a literature review to identify evidence-based models of care for young people with severe and complex mental illness.

Evidence-based models include:

- Stepped care
- Primary care provider-delivered mental health care
- Primary care in school-based settings
- Collaborative care
- Consultation and liaison
- Case management
- Replacement/referral

Other models of care such as interventions delivered without clinical guidance or hospital-based services may be suitable for young people with severe mental illness, but are not covered in this summary.

2.1 Stepped care

Stepped care is a staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. While there are multiple levels within a stepped care approach, they do not operate in silos or as one-directional steps, but rather offer a spectrum of service interventions. Stepped care is a different concept from 'step up/step down' services. In a stepped care approach, a person presenting to the mental health system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest or least intensive level of intervention to progress to the next 'step'. Rather, they enter the system and have their service level aligned with their requirements.

2.2 Primary care provider-delivered mental health care

Primary care provider-delivered mental health care refers to care delivered by general practitioners (GPs), and may include other health professionals such as psychologists and mental health workers. Evidence shows that the provision of mental health care in primary care settings improves patients' access to and satisfaction with mental health care. Treatment by mental health workers co-located within general practice improves the frequency of referrals to these workers by GPs. Quality training is important in this model, and includes training on the implementation of relevant guidelines and use of interventions, rather than just the provision of information. Evidence shows the number, quality and appropriateness of referrals improves after training for GPs.

2.3 Primary care in school-based settings

General practitioners delivering mental health services within school-based or linked settings offer care in an accessible, youth-friendly environment. School-linked health centres have formal or informal relationships with one or more schools within the community, without
necessarily being sited within schools. Primary care mental health providers involved include physicians, nurse practitioners, social workers, counsellors and psychologists.

Evidence indicates that adolescents with access to school-based mental health providers have significantly more service contacts. Those exhibiting high-risk behaviours, suicidal ideation and depression are particularly likely to access mental health services located within a school setting. Accessibility is increased for underserved youth including males, students from ethnic minorities and low socio-economic groups.

Adolescents endorse school health centres due to their accessibility, convenience, confidentiality and youth-friendly staff. Close collaboration between medical professionals, students, parents, teachers and community providers is viewed as essential in the planning and implementation of these services.

### 2.4 Collaborative care

Collaborative care is a complex model that involves GPs, mental health professionals and case managers working together to deliver a package of care to patients. The case manager may provide multi-agency care coordination, ongoing assessment, assistance with self-care, brief psychological therapy and medication management. The GP has responsibility for the generalist care such as diagnoses and assessment, the mental health specialist provides consultation and supervision, and the case manager liaises with the GP and specialist around quality of care. Effective service delivery is characterised by collaborative client involvement, the development of a strong therapeutic alliance and individualisation of treatment in relation to client needs.

This model tailors care to suit the clinical needs of the patient, and increases access to care for disadvantaged and high priority groups. There is strong evidence for its effectiveness treating serious mental illness in young people when compared to usual care.\(^9\) It can improve the effects of psychological and pharmacological therapies, and lead to better clinical outcomes. The incorporation of evidence-based interventions such as guideline medication protocols or cognitive behavioural therapy (CBT) can increase effectiveness for disorders such as depression. In ‘high-risk’ youth experiencing a first episode of psychosis, assertive outreach involving intensive case management leads to significant reductions in service usage and improvements in psychological outcomes. Intensive case management is also effective in transition-age youth (18-25 years) with bipolar disorder, schizophrenia or schizoaffective disorder in regards to improved social and vocational functioning, and lower rates of hospitalisation. The model provides a strong foundation for care that is person-centred, culturally appropriate, and improves a patient’s quality of life.

The initial set-up cost for collaborative care is significant, but is later offset by decreases in a patient’s involvement in specialist care and other systems, such as the criminal justice system.

### 2.5 Consultation and liaison model of care

The consultation and liaison model involves mental health specialists entering an ongoing relationship with a GP to support them in diagnosing and delivering mental health care to patients. This model is designed to provide outpatient psychiatric support to GPs for patients who require specialist treatment. It expedites access to outpatient psychiatric consultation to
GPs, while maintaining the GP as the organiser of ongoing collaborative care. It is best suited for those diagnosed with depression, anxiety or ADHD who do not require long-term psychiatric care. Evidence shows that the model is an effective adjunct to collaborative care, but does not result in significant improvements in clinical symptoms if delivered in isolation. An important consideration is the development of appropriate funding mechanisms and reimbursement strategies to provide coordinated and integrated care.

2.6 Case management
Case management is a collaborative process of assessment, planning, facilitation, evaluation and advocacy to meet an individual’s and family’s health needs. Case management has been shown to be effective for a range of subgroups including high risk youth with a history of limited contact with mental health services or experiencing a first episode of psychosis, as well as during the transition to adulthood. Case management provides a strong foundation for care that is person-centred, culturally appropriate, and improves a patient’s quality of life.

Case management assigns the coordination and responsibility of care for an individual to a single person (or team). The case manager is responsible for a variety of tasks, ranging from linking young people and families to service providers, to providing intensive clinical or rehabilitation services. Other functions could include outreach to engage clients in services, assessing individual needs, arranging support services and facilitating medication management. Case managers should be appropriately qualified to provide psychological interventions, thereby ensuring timely therapeutic care.

2.7 Replacement/referral
In a replacement/referral model, the GP refers patients to a mental health specialist to deliver psychological therapy. Intensive therapies such as cognitive behavioural therapy and interpersonal therapy are effective at least in the short-term, whether directly therapist led or self-guided. Evidence shows that the replacement/referral model of care benefits patients with persistent mild depression more than patients with severe depression. Adequate time, access to supervision, and practice support are enablers to GPs in assisting young people with mental health problems.
3. Current provision of psychological intervention by disease severity

The diagram below outlines current and planned provision of psychological interventions by severity of disease. These services are shown as a series of steps, mirroring a stepped care model.

Some advantages and disadvantages of the current service system are:

✔ Medical management is available through general practice and psychiatrists, funded by Medicare.

✘ There is a significant shortage of child & adolescent psychiatrists in Tasmania.

✔ Psychologist interventions are funded by Medicare under the Better Access program and by the Australian Government under Primary Health Tasmania’s Short Term Psychological Interventions program (formerly known as ATAPS).

✘ There is a limit of ten sessions per calendar year. For young people with severe and complex mental illness, this may not be sufficient.

✔ Case management is provided by some general practitioners as well as allied health professionals, including through the education and community sectors.

✘ Overall, there is limited case management is provided.

✔ Community support services are provided by many not-for-profit organisations throughout Tasmania.

✘ While service providers have identified a need for additional investment in this area, the Australian Government has identified these services as out of scope for this funding.
4. Stakeholder consultation outcomes

Consultations about mental health services for young people (aged 12-25) with severe mental health illness were undertaken in two stages.

Initial consultations were undertaken by University of Tasmania – Centre for Rural Health, on behalf of Primary Health Tasmania. These consultations included general practitioners, clinicians and managers from Tasmanian Health Service mental health services, private psychologists, consumer and carer organisations, community support organisations and peak bodies with an interest in mental health. The consultations aimed to identify service gaps, highlight barriers and enablers to service use, and make recommendations about the design of appropriate service models.

Following these initial consultations, Primary Health Tasmania convened a stakeholder forum to develop service models for commissioning. In parallel, a survey was released online. Fifty-three people attended the stakeholder forum and 38 people responded to the online survey.

4.1 Key findings from initial consultations

Initial consultations identified that a significant proportion of young people with severe mental illness were not able to access appropriate services. Respondents in consultations identified that access to services varied by age group and by diagnosis.

Barriers to accessing youth mental health care

Four main themes relating to barriers to youth accessing mental health care were identified from the respondents:

1. **Poor communication and collaboration**

Participants described poor communication and collaboration between service providers, and inflexible guidelines leading to confusion, inefficiency and inflexibility in key components of the treatment process (e.g., referral, intake) for both clients and service providers.

2. **Stigma and low mental health literacy**

Participants identified stigma and poor mental health literacy as significant barriers to young people accessing care. This included poor awareness and understanding of mental health problems, and available treatment and services. Young people, their families and friends, community members and health practitioners experience this lack of awareness and understanding. Participants highlighted this issue as particularly significant in rural/remote areas.

3. **Lack of age appropriate rural/remote services**

Participants reported a lack of public, youth-oriented/friendly, age-appropriate services in rural/remote areas. This also included a lack of dedicated inpatient facilities, after-hours services and assertive outreach and follow-up services. Participants described this gap as leading to long wait lists for and over-burdening of certain key services (e.g., CAMHS), clients receiving age-inappropriate (or no) care, being shunted between service providers or otherwise being left in limbo.
4. Lack of adequate support/infrastructure for young people and their carers

Participants described a lack of adequate support/infrastructure for young people and/or their carers to attend services where these are available. This included a lack of adequate public transport, housing and financial support, particularly in complex cases where social support was lacking.

Service design recommendations

Seven themes were evident across most participants’ responses and provide guiding principles that could underpin the design of a quality youth mental health service.

1. Prevention/early intervention

Participants recommended a reorientation of services to symptom management rather than crisis management.

2. Community-based

Participants recommended a community approach to addressing stigmatisation, the appointment of community based ambassadors for mental health, and stronger links with and between community support services.

3. Service model

Participants described an ideal service model as flexible and adaptive, collaborative, holistic, and with scaffolding pre- and post-intervention. Participants suggested services should be underpinned by specialist services and offer combined inpatient/outpatient facilities with good follow up.

4. Education and training

Participants advocated for increased education at a systems level for both communities and practitioners across the lifespan. In particular, mental health literacy programs for the broader community were seen as an important step in reducing stigma, with mental health literacy seen as a shared responsibility.

5. Alignment of services

Several respondents stated better alignment of services would contribute to improved outcomes. In particular, improved coordination between services, seamless transition both within and between services, alignment of age grouping between services, and a stepped-up model of care supported by skilled practitioners would improve outcomes.

6. Access

Respondents regarded a quality service as one that is characterised by ease of access and transition from point of entry to treatment and recovery. Participants advocated place-based solutions, outreach to support isolated communities, 24-hour access, and a supportive, youth-friendly location.

7. Resources

Participants expressed that the ideal service model could only work effectively if it was supported by consistent policies and frameworks across the mental health sector, stable resourcing, staffing, and widely-recognised branding.
4.2 Key findings from stakeholder forum and survey

The forum and survey confirmed findings from the earlier consultations and identified priority areas for investment by Primary Health Tasmania.

Case management

Both survey and forum participants highlighted the need for improved case management with person-centred, coordinated care between multiple providers. Participants identified counselling and psychological services as key components of service provision and the importance of involving multiple practitioners in completing a holistic assessment to inform care planning. Participants identified the need for a trusted core provider who could help coordinate, and where necessary navigate young people through their continuum of care was also highlighted.

Role of schools

There was general agreement about the importance of schools in educating young people about when and where to seek help, identifying young people potentially at risk and assisting them to access appropriate professional care (mostly via referral pathways). School-based and collaborative care models were seen as effective ways to improve service access among people not already using services. Professional connections with schools were encouraged to enable these support activities to occur. However, there was minimal identification of schools as an appropriate setting for therapeutic activity (e.g. group sessions).

Stepped care

Most participants identified components of the stepped care approach (e.g. defined care pathways) as being valuable in enabling young people to access the appropriate set of services relevant to their condition, in preference to models that were heavily reliant on specialist consultation.

Improving access to services

Several avenues to increase access to young people were proposed. These included harnessing community organisations and groups with access to adolescents; having connections between service providers seeing young people and linking youth relevant interventions; using technology innovatively and improving existing service accessibility, including through improved transport. Headspace was identified frequently as a good model for service provision and improving access for young people. The need for outreach services and access across Tasmania to services specific to certain disorders (e.g. eating disorders) were identified.

Mental health workforce

Participants identified the need to upskill the current workforce and to provide clinical support to varied roles across varied services. The need for a multidisciplinary, culturally sensitive, person-centred workforce was also highlighted.
5. What could services look like in the future?

Consultations have identified a gap between services for young people with moderate mental illness and for those with the most severe mental illness.

Consultations identified the following core components of care for young people with severe and complex mental illness.

Young people with severe mental illness need several core components to their care:

- Medical management by a GP and a psychiatrist (with adolescent and youth expertise)
- Psychologist interventions (individual, group and/or digital)
- Community psychosocial support services (eg. housing, employment)
- Case management
Primary mental health services for young people with, or at risk of, severe and complex mental illness

PHASE 2 – DESIGNING SOLUTIONS

Defining the most achievable solution that can be implemented

- Understanding the problem to be addressed
- Understand evidence informed ways to address the problem
- Understanding the local service delivery context and capability
6. Service commissioning options

6.1 What outcomes will be commissioned?

Commissioned primary mental health services for young people with, or at risk of, severe and complex mental illness must align with our overarching organisational PHN objectives to:

- to increase the efficiency and effectiveness of medical services for patients - particularly those at risk of poor health outcomes; and
- to improve the coordination of care to ensure patients receive the right care in the right place at the right time

Our overarching objectives, evidence from the literature and stakeholder engagement have informed the commissioning design for determining the outcomes that commissioned services must deliver against. These outcomes are listed below:

- improved case management and care coordination at the local level for youth with severe mental illness
- increased access to specialist psychological services for young people with severe mental illness
- reduced use of higher level 'steps' in a stepped model of care, with increased use of lower level/preventative/primary care

6.2 What services are within scope?

1. Case Management

Case management provides a strong foundation for care that is person-centred, culturally appropriate, and improves a patient’s quality of life. Case management is a collaborative process of assessment, planning, facilitation, evaluation and advocacy to meet an individual’s and family’s health needs. Case management has been shown to be effective for a range of subgroups including high risk youth with a history of limited contact with mental health services or experiencing a first episode of psychosis, as well as in transition-age youth with severe mental illness.

Case management assigns the coordination and responsibility of care for an individual to a single person (or team). The case manager is responsible for a variety of tasks, ranging from linking young people and families to service providers, to providing intensive clinical or rehabilitation services. Other functions could include outreach to engage clients in services, assessing individual needs, arranging support services and facilitating medication management. Case managers should be appropriately qualified to provide psychological interventions, thereby ensuring timely therapeutic care.

2. Psychological interventions

Psychological interventions refer to a range of therapeutic approaches which reflect best available evidence and can include psycho-therapeutic, psycho-educational, rehabilitative and collaborative approaches using individual and/or group methods. Online and digital application approaches can also be used.

Services must demonstrate that the proposed psychological interventions have a strong evidence base and will be delivered by suitably qualified health professionals.
Other requirements:

**Referral pathways**
Service proposals must ensure there are formal referral pathways and links to:
- Psychosocial support services (eg. housing, disability, employment);
- Medical management (primary care and (ideally) psychiatric care);
- Services for young people with increased severity of symptoms; and
- Services for patients in acute crisis, including after hours.

**Location of services**
Services do not need to be delivered state-wide. Consideration should be given to improving service access for young people living in rural areas and building capacity within rural areas to provide ongoing support for these young people. Regional approaches and strong networks are encouraged to ensure a cohesive service system.

**Innovation and cost-effectiveness**
Innovative service models are encouraged. Service models should make cost-effective use of existing and new resources.

### 6.3 Out of scope
Program funds cannot be used for the following:
- Capital works
- Actions that duplicate existing funded activities that are primarily the responsibility of state and territory governments
- Social support services, including disability and psychosocial support.
6.4 How will tenders be assessed?

In line with the commissioning intention, Primary Health Tasmania will assess tenders based on four criteria, as summarised at Table 1 and detailed at Table 2.

Please note this information will appear as a series of questions in the online Request for Tender application documentation.

**Table 1: Request for Tender assessment criteria summary**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The service model</td>
<td>35%</td>
</tr>
<tr>
<td>2. Organisational capability</td>
<td>25%</td>
</tr>
<tr>
<td>3. Workforce skills and capabilities</td>
<td>15%</td>
</tr>
<tr>
<td>4. Resource management</td>
<td>25%</td>
</tr>
</tbody>
</table>

Further detail on the focus for each criterion is provided below.
Table 2: Detailed tender assessment criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Service Model</td>
<td>35%</td>
</tr>
<tr>
<td>Outline the service model the organisation intends to implement. Include details on the following elements:</td>
<td></td>
</tr>
<tr>
<td>• Describe the service model proposed and include what case management and psychological interventions services will be delivered, and the relevant evidence base and service standards that supports the model/s.</td>
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<tr>
<td>• Outline the extent to which the service model and client management pathways have been developed in collaboration/partnership with relevant service providers and organisations including the Tasmanian Health Service, particularly Child and Adolescent Mental Health Services (CAMHS) and Adult Community Mental Health Services (ACMHS), and how the proposed model/s will maximise collaboration and coordination between service providers in a stepped care approach, on commencement of service provision and ongoing.</td>
<td></td>
</tr>
<tr>
<td>• Outline the specific shared care arrangements that will be in place between service providers, including the proposed service model provider/s, Child and Adolescent Mental Health Services (CAMHS) and Adult Community Mental Health Services (ACMHS), Shared care arrangements should include processes for the management of changes in client acuity, including after hours. Describe the arrangements for the safe management of clients on commencement of service provision.</td>
<td></td>
</tr>
<tr>
<td>• How does the proposed model promote person-centred care, and shared communication with carers and families, and with referrers and other services?</td>
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<tr>
<td>• Outline the population/s targeted by the service model/s, including criteria related to service access and client eligibility</td>
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<tr>
<td>• Outline the location or catchment area for the proposed service/s, including the rationale behind any specific regional approach</td>
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<tr>
<td>• Outline the health outcomes intended to be achieved for the target population group and the measures that will be used to demonstrate achievement of these outcomes. Health outcome measures may include, reduction in hospitalisation rates, reduction in crisis intervention requirements, increased linkages with other services, increased level of wrap-around supports, and client/carer qualitative measures of service satisfaction.</td>
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<tr>
<td>• Outline electronic information management systems that will be utilised for service provision, reporting and health outcome monitoring.</td>
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<tr>
<td>• How does the proposed model ensure access to and the delivery of culturally safe services to Aboriginal and Torres Strait Islander Peoples?</td>
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<tr>
<td>• How does the proposed model meet the service needs of diverse population groups such as people from culturally and linguistically diverse (CALD) backgrounds, and people who identify as lesbian, gay, bisexual, transgender, and intersex (LGBTI)?</td>
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</tr>
<tr>
<td>2. Organisational Capacity</td>
<td>25%</td>
</tr>
<tr>
<td>Outline a response against the following considerations to ensure services provide safe, reliable and appropriate access to clients:</td>
<td></td>
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<tr>
<td>• Detail the type of services that your organisation currently provides and provide evidence of organisational leadership and governance arrangements, including strategic, risk management, business and operational plans which relate to the performance and delivery of your proposal.</td>
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<tr>
<td>Criterion</td>
<td>Weighting</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>• State whether the organisation is currently accredited or working towards accreditation (include to which health care standards and with which accrediting body).</td>
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<tr>
<td>• If your organisation is not accredited – what continuous quality improvement does your organisation undertake to inform and improve service delivery?</td>
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</tr>
<tr>
<td>• How does your organisation ensure adherence and compliance with all relevant legislation, health care standards and regulatory requirements including workplace safety standards, systems and procedures?</td>
<td></td>
</tr>
<tr>
<td>• Describe your organisation’s clinical governance, safety and quality arrangements to ensure the service is safe, effective, and of high quality, including policies and protocols for managing clinical accountability and risk.</td>
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<tr>
<td>• Describe what your organisation does to ensure adequate service access and consumer input and feedback into service design, delivery and evaluation.</td>
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<tr>
<td>• Describe your organisation’s processes and systems to record and act upon client compliments and complaints, and how you actively seek feedback.</td>
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<tr>
<td>• Describe how you manage and inform client consent, confidentiality and health care rights and responsibilities. Include how you enable clients to easily access information.</td>
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<tr>
<td>• Describe your organisation’s processes to manage clinical service delivery and organisational risks, incidents (or adverse events) and near misses. Include how you enable open disclosure of these risks and incidents to clients/carers/families.</td>
<td></td>
</tr>
</tbody>
</table>

3. Workforce skills and capabilities

Outline a response against the following considerations that ensure the proposed workforce has the appropriate skills and capabilities

• Describe your organisational systems that ensure you have appropriately credentialled and qualified staff to deliver quality and safe services. Include information on recruitment and orientation, scope of practice, performance review, relevant professional membership(s), and/or professional registration, supervision and ongoing development.

• Provide the names, positions, brief CVs of the proposed key personnel who will undertake the works, and any relevant skills, training and credentialing. Advise if you will need to recruit some or all the required workforce, and/or if training would be required before staff can provide the services.

• Outline any innovative workforce approaches you plan to implement as part of your proposed service model.
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Resource Management</strong></td>
<td>25%</td>
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<tr>
<td>Provide a response against the following aspects to demonstrate that the organisation is financially sustainable:</td>
<td></td>
</tr>
<tr>
<td>• Outline the systems within the organisation to ensure financial compliance and how financial acquittal and reporting obligations will be met. Include proof of your organisation’s financial sustainability (e.g. letter from accountant, audited financial report, summary statement.)</td>
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<tr>
<td>• Describe how your organisation’s proposal represents value for money.</td>
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<tr>
<td>• Provide a breakdown of all costs associated with your proposal to deliver the services: including hourly rates, travel, accommodation, materials, and any establishment one-off costs (please provide cost inclusive and exclusive of GST). Please use the attached budget template.</td>
<td></td>
</tr>
<tr>
<td>• Outline the approach that your organisation takes to ensure that physical assets are managed in accordance with recognised best practice.</td>
<td></td>
</tr>
<tr>
<td>• Provide details of current insurances including type, insurer, policy number, value of cover and expiry date. (Preferably provide copy of certificates).</td>
<td></td>
</tr>
<tr>
<td>• Please provide details for organisations that you nominate as a referee, please include a contact name, phone number and email address.</td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
6.5 Assessment Process

Primary Health Tasmania will form a tender assessment panel, which will include internal representatives, along with external expertise from the mental health sector and an independent probity advisor. The panel will be guided by several fundamental principles in undertaking this role. These are:

- Independence
- Expertise, knowledge and experience
- Ethics
- Conflict of interest
- Confidentiality and security of information.

Primary Health Tasmania will assess tender based on the 4 criteria using a weighted evaluation methodology (shown as percentages in Table 2), along with consideration of:

- state-wide needs;
- distribution of services; and
- comparative value for money of proposals.

Primary Health Tasmania acknowledges that some aspects of effective service models will require development over time and that applicants may not have all the components in place at the time of preparing the proposal. Where components are not in place, applicants are asked to:

- describe the current status, steps and time that will be taken to establish these components, including any areas of identified need for support
- specify within the proposed budget if one-off funds will be required for these establishment activities.

6.6 Contract term

The contract term is from mid-February 2017 – 30 June 2018. Successful providers will be expected to work closely with Primary Health Tasmania and our system partners between being notified as a successful organisation and during January 2017 to negotiate and refine the proposed model of care and ensure preparedness for commencement of services in February 2017.

6.7 Preparing and submitting your tender

- All tender applications must be submitted via Primary Health Tasmania’s Tenderlink portal [https://www.tenderlink.com/primaryhealthtas/](https://www.tenderlink.com/primaryhealthtas/).
- Respondents are encouraged to seek clarification on issues relating to the tender. All questions on clarifications received from applicants during the open process must be submitted in writing using the online forum within Tenderlink.
- When a question is received, the Primary Health Tasmania procurement advisor receives all alerts around questions and will liaise with the project support officer/project manager to obtain the necessary response accordingly. Responses will be made available on the Tenderlink online forum.
- Further information on the general terms and conditions can be found at Tenderlink.
6.8 Resources available from Primary Health Tasmania?

A range of resources are available on the Primary Health website to assist with the planning and development of Request for Tender applications and services for young people with or at risk of severe and complex mental illness. These can be found at: http://www.primaryhealthtas.com.au/commissioning/mental-health-services-commissioning

6.9 Key dates for commissioning of primary mental health services for young people with, or at risk of, severe and complex mental illness

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Request for Tender invitation and assessment milestones</strong></td>
<td></td>
</tr>
<tr>
<td>25 November 2016</td>
<td>Request for Tender opened via Tenderlink at 4pm</td>
</tr>
<tr>
<td>22 December 2016</td>
<td>Tender applications close at 2pm</td>
</tr>
<tr>
<td>3-19 January 2017</td>
<td>Tender evaluation, shortlisting and selection</td>
</tr>
<tr>
<td>23 January – 6 February 2017</td>
<td>Contract negotiations and execution (including submission of detailed project plan and finalisation of specific outcome measures, monitoring and reporting)</td>
</tr>
<tr>
<td>13 February 2017</td>
<td>Service delivery commences</td>
</tr>
<tr>
<td>30 June 2018</td>
<td>Contract completion</td>
</tr>
</tbody>
</table>