Stepped Care Model & Principles

**Well Population**
- Public information
- Self-help strategies
- Digital mental health services

**At Risk Groups**
- Public information
- Self-help strategies
- Digital mental health services
- Peer supports
- GPs and allied health services for those who require them

**Mild Mental Illness**
- Public information
- Self-help strategies
- Digital mental health services
- Peer supports

**Moderate Mental Illness**
- Public information
- Self-help strategies
- Digital mental health services
- Peer supports
- Face-to-face primary care and clinician-assisted digital mental health services
- GPs and allied health professionals

**Severe Mental Illness**
- Public information
- Self-help strategies
- Digital mental health services
- Peer supports
- Coordinated, multiagency, face-to-face clinical care

**Health Promotion**
- Early Interventions
- Low Intensity Services

**Face-to-Face Services**
- Multiagency Care

1. Matched to choice & need
2. Flexibly adapt to change
3. User focused referral
4. Service options provided
5. Client led focus & plans
6. Crisis pathways
7. Flexible access
8. Connected services & supports
9. Quality accountability
10. Focus on underserviced groups

Stepped Care diagram produced by Central and Eastern Sydney PHN, guided by the 2016 Australian Government framework, PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care, available from the Department of Health website at www.health.gov.au
STEPPED CARE PRINCIPLES

1: Matched to choice & need
Service intensity is matched to need. The ideal intervention is the least intensive and least intrusive, but most likely to lead to the most significant possible gain. Importantly, the decision is driven by client choice. The System where possible should align to the needs of the person, rather than the person having to align to the system.

2: Flexibly adapt to change
Stepped care approaches recognize that peoples’ needs can change over time and therefore services should have the flexibility to cater for these changing needs.

3: User focused referral
Flexibility is critical and allows an individual to move with ease across services without necessarily needing to be re-referred, and re-tell their story. Assessment and review is embedded and ongoing.

4: Service options provided
PHNs will aim to commission and connect a broad mix and range of services to meet community needs. The goal being to address demand, and provide individuals with choice and service options.

5: Client led focus and plans
Recovery plans and arrangements are led by the consumer, focused on their needs and goals and connect members of their care and support team including family and carers if desired.

6: Crisis pathways
Through regional integration, there is always a pathway available to those with high or urgent needs and access to specialist mental health services is fast-tracked.

7: Flexible access
Improved access is essential, and is supported by clearer referral processes, extended service hours, flexible modes of delivery, and readily available support to navigate services.

8: Connected services and supports
The focus is not only on the services commissioned by the PHN, but also includes informal supports, primary care, specialist supports, hospitals, NDIS, non-government, private and social supports.

9: Quality accountability
Providers lead robust operational process, with clinical governance in place, quality management and improvement, reportable and measurable outcomes, evidence based interventions- all of which have a meaningful and measurable impact on population health needs identified in regional needs assessments.

10: Focus on underserviced groups
The system is adaptive to changing local community needs and policy and service directives. PHNs focus on the populations and communities that are underserviced, at risk and who traditionally find services difficult to access.