



Australian Government

Department of Health

PHN PRIMARY MENTAL HEALTH CARE FLEXIBLE FUNDING POOL IMPLEMENTATION GUIDANCE

PRIMARY MENTAL HEALTH CARE SERVICES FOR PEOPLE WITH SEVERE MENTAL ILLNESS

PHNs are required to commission primary mental health care services through the primary mental health care funding pool for people with severe mental illness being managed in primary care, including clinical care coordination for people with severe and complex mental illness through the phased implementation of primary mental health care packages and the use of mental health nurses.

PHNs may also, separately, play a role in the provision of broader support services for people with severe mental illness through programs such as Partners in Recovery (PIR). However, this guidance focuses on services funded through the primary mental health care flexible funding pool.

In 2016-17 PHNs are expected to:

- commence the development and delivery of services for young people with, at or at risk of, severe mental illness;
- commission mental health nursing services to support clinical care coordination for people with severe mental illness, ensuring service continuity to existing MHNIP clients and developing new services in those areas with allocated growth;
- encourage GPs and other regional providers to address the physical health inequities of individuals with severe mental illness within the region;
- promote the better integration of primary care services with community based private psychiatry services and state mental health services for people with severe mental illness in the context of the development of regional Mental Health and Suicide Prevention Plans; and
- ensure referral pathways are in place to enable and support patients to seamlessly transition between services as their needs change.

In addition, a small number of lead PHNs have been invited to trial models of innovative funding to support clinical care packages for individuals with severe and complex mental illness.

Longer term PHNs will be expected to:

- informed by the lessons from PHN lead sites, develop and commission clinical mental health services to support the needs of people with severe and complex mental illness who are best managed in primary health care;
- promote the use of a single multiagency care plan for people with severe and complex mental illness, to help link providers across multiple services involved in an individual's care and to promote a medical home approach;
- engage with the private mental health care sector to ensure links are in place with private hospitals and psychological services to support care coordination; and
- ensure referral pathways are in place to enable and support patients to seamlessly transition between services as their needs change.

Approximately 690,000 Australians are estimated to have severe mental illness (based on epidemiological data). The needs of people with severe mental illness are not homogenous. Some people have episodic illness which can be supported through time-limited clinical services in the primary care setting. Others have more persistent mental illness that requires more acute, hospital based services and a need of some form of social support, ranging from group-based activities delivered through mainstream social services to extensive and individualised disability support.

Commonwealth, state and territory funded service providers and the National Disability Insurance Scheme (NDIS) all play critical roles in the care of people with severe mental illness.

In primary care, a significant number of people with mental illness (around 360,000) are currently managed by a psychiatrist, with most of these having a severe mental illness. Many others with severe mental illness rely mainly on general practitioners (GPs) to provide both mental health and physical health services. Young people with, or at risk of severe mental illness are a particular group that needs to be considered for primary care services. GPs will continue to have a central role in providing assessment, treatment and referral services for people with severe mental illness who can be appropriately managed in the primary care setting. Mental health nurses have played a key role in primary care in helping to provide clinical care coordination for people with severe mental illness managed by GPs and psychiatrists. In addition, programs such as Better Access contribute to overall service delivery to this client group when they are managed within a primary care environment.

Clinical services to people with severe mental illness to be commissioned by PHNs through the flexible funding pool are those which:

- provide evidence based intervention (e.g. cognitive behavioural therapy) to people with severe mental illness who can be appropriately managed in the primary care setting as part of their overall treatment;
- complement and enhance existing GP, psychiatrist and allied mental health professional services available through the Medicare Benefits Schedule (MBS);
- offer the right frequency and volume of services to meet the needs of people with severe mental illness (e.g. the right number of occasions of service at the right time);
- are provided by a suitably skilled and qualified workforce, working within their scope of practice, matched to the needs of those accessing the services;
- are consistent with relevant standards and legislative/regulatory requirements, and align with the standards articulated in the *National Standards for Mental Health Services 2010*;
- promote recovery, and align with the *National Framework for Recovery Oriented Mental Health Services 2013* where relevant;
- are coordinated with other health and support services to provided people with severe mental illness and complex needs;
- provide links to other services within a stepped care approach to ensure people are matched to a service commensurate with their mental health need; and
- address the needs of young people with or at risk of severe mental illness.

Activities that are not considered to be in scope for services commissioned by PHNs through the flexible funding pool for people with severe mental illness include those which:

- are not supported by an empirical evidence base;
- duplicate other existing services provided by other organisations, including state and territory government services, the NDIS, MBS, or other national initiatives;
- provide services that would be more appropriately delivered within an acute or hospital setting or by state specialised mental health services; and
- are solely focused on providing broader social support services that are the responsibility of the disability support/non-health sector.

Generally, PHNs cannot commission psychosocial support services from the flexible primary mental health funding pool, with the exception of limited vocational or education support, or services relevant to suicide prevention actions. However, it is recognised that broader support services, including services provided beyond the health sector, are vital to support the holistic care of people with severe and complex illness. PHNs therefore have an important role in promoting links and easy to navigate referral pathways between clinical services and broader support services for people with mental illness, including relevant services provided by LHNs and through the NDIS.

Links to programs such as Partners in Recovery (PIR) and Day to Day Living (D2DL) should also be encouraged although these programs are outside of the flexible primary mental health care funding pool, even in those circumstances where PHNs are lead sites for implementation of PIR.

The Health Care Home model for chronic disease management is a separate, but complementary, initiative to PHN commissioned services for people with severe mental illness and has a separate implementation timeframe. Refer to the 2016-17 Federal Budget information for further detail on the Health Care Home model (<http://www.health.gov.au/internet/budget/publishing.nsf/Content/healthbudget1617-1>).

What is expected of PHNs?

In 2016-17

PHNs are required to develop and commission clinical mental health services to meet the needs of people with severe mental illness who can be appropriately managed in the primary care setting. In the first year, this includes making optimal use of the available and new mental health nursing services to support the clinical care coordination of people with severe mental illness.

PHNs are expected to develop partnerships and linkages in the region with key stakeholders and organisations to support integration of services around individual's needs. This needs to include state and territory mental health services and NDIS service providers to establish arrangements to support the needs of people with severe and complex mental illness who are principally managed in primary health care. Linkages and referral options are also needed to ensure that people with severe mental illness who cannot be appropriately managed in the primary care setting are supported across to more suitable services, such as specialist community and inpatient mental health services managed by LHNs operating in the region.

PHNs should optimally engage and support psychiatrists in the region in supporting primary care services for people with severe illness, through their role as consultant physicians,

undertaking detailed assessments and care plans, and in working with mental health nurses commissioned under the previous Mental Health Nurse Incentive Program (MHNIP). Commissioned services should be encouraged to put in place clear referral protocols to psychiatrists and other specialist services.

PHNs are also encouraged to promote mechanisms to help address the physical health needs of people with severe mental illness among regional providers, through commissioning arrangements and in the context of developing regional mental health and suicide prevention plans, and through the promotion of single multi-agency care plans where appropriate.

In addition to this broader work across all PHNs, selected PHN sites are taking the lead in early implementation of service models for clinical care coordination for people with severe and complex mental illness. This lead site activity commences in 2016-17 and will inform full national implementation by the end of the three year implementation period for mental health reform (i.e. by the end of 2018-19) through exploring innovative funding models to support clinical care coordination and packaged care arrangements. PHNs not participating in these sites in 2016-17 will **not** be expected to deliver clinical care packages for those with severe and complex mental illness that entail funding innovation, but should take steps to make more optimal use of existing funding streams by better linking mental health nurse services with other primary care services.

In the longer term

In the longer term, it will be expected that clinical care packages for people with severe mental illness and complex needs will be implemented across all PHNs, informed by the early implementation experience of the selected lead PHN sites.

GPs will continue to have a key role in assessments. However additional assessment arrangements for people with severe and complex mental illness will be expected to be developed by PHNs to support longer term packaged care arrangements and supplement the central role of general practitioners and offer additional services to those people who have complex needs and would benefit from a coordinated approach to the provision of clinical services. These assessment processes will also need to link to state-funded LHN and national NDIS assessment and referral to help match people to the service pathway which best meets their needs.

Clinical governance will be expected to be established to ensure the clinical appropriateness of systems established and services commissioned. Over the longer term, PHNs will be expected to ensure that services commissioned are consistent with relevant national standards, such as the *National Standards for Mental Health Services 2010*, the *National Practice Standards for the Mental Health Workforce 2013*, and all other relevant standards and legislative/regulatory requirements.

PHNs will be required to monitor and report on their activities in relation to services for people with severe mental illness, including care coordination for people with severe and complex mental illness. Consumer outcomes data will be needed in this context. Data and reporting arrangements are currently under development. PHNs will be expected to provide data on mental health nursing services through the data and reporting

arrangements currently under development. Further information on these arrangements will be provided soon.

It is important that PHNs only commission services for those people with severe mental illness who can be appropriately managed in the primary care setting (i.e. who do not require more specialised and intensive service delivery within the state and territory managed specialised mental health system).

People with severe mental illness may require assistance from a number of agencies such as general practitioners (GPs), mental health and medical specialists, and allied health providers, ranging across Commonwealth, state and community boundaries. PHNs are encouraged to promote the use of multi-agency care plans for people with severe and complex mental illness, to help link providers across multiple services involved in an individual's care, efficiently document delivery of services and promote a medical home approach.

Safety and Quality

PHNs are expected to ensure a high level of service quality for services commissioned within a stepped care approach. PHNs need to establish mechanisms to ensure commissioned providers and consumers are aware of local crisis services and pathways.

It is expected that the workforce involved in delivering PHN commissioned services is appropriately qualified, skilled and competent to provide relevant interventions, in line with professional scope of practice where applicable. PHNs should ensure appropriate clinical supervision arrangements are established to maintain the safety and quality of commissioned service provision. PHNs also need to establish policies for managing complaints. PHNs should in particular engage with local psychologists in developing approaches to care for this group.

Relevant national standards (such as the *National Standards for Mental Health Services 2010*, the *National Practice Standards for the Mental Health Workforce 2013* and the *National Framework for Recovery Oriented Mental Health Services 2013*) regulations and guidelines should be applied where relevant to promote service quality and effectiveness.

Responsibility for managing a particular individual's care may at times be transferred between primary care and state or privately funded specialist services, particularly given the episodic nature of some severe mental illness. Given the potential vulnerability of this group of clients, where a patient is transferred to another service, a duty of care exists for the commissioned service to ensure that the receiving service has accepted care of the client and is aware of their needs. It is also vital that the commissioned service communicates to the client the nature of and the reason for the changed arrangements and that the client is clear on how to access the services.

What flexibilities do PHNs have?

There is only very limited flexible funding available in the first year of the funding pool arrangements to support new activity targeting service provision to people with severe

illness. However PHNs have the opportunity to better link existing services, plan for better coordination and promote good practice from the outset.

In relation to mental health nursing services, in 2016-17 PHNs are required to commission mental health nursing services through existing providers of the MHNIP (e.g. GP and psychiatry practices). PHNs which currently provide MHNIP services through employment of mental health nurses are required to commission these services in 2016-17 and beyond. However, where this is not possible to achieve by 1 July 2016, they can continue to employ mental health nurses in the short term during the 2016-17 transition year to ensure continuity of services to existing clients while they finalise the commissioning process.

In 2016-17, PHNs that receive additional funding to address regional service distribution inequities in the MHNIP have the flexibility to determine the best way to ensure equitable service distribution in their region(s) and commission services accordingly. PHNs commissioning existing and new services have flexibility to ensure that services are targeting the need for clinical care coordination for people with severe illness and linked to other services which they commission – and to guide services which they consider may not be targeting this need.

From 2017-18 PHNs will have full flexibility to determine how mental health nursing services will be delivered across their region.

Some flexible new funding will be available for developing early intervention services for young people with severe mental illness (a separate guidance document is available on Child and Youth). There will also be some flexibility to utilise some funding for underserved groups to target the needs of members of these groups with severe illness, within the context of a stepped care approach, and the need to maintain an appropriate mix of primary mental health care services and support a broad range of people with mental illness.

Over the three year implementation period, PHNs will develop and implement models to provide clinical care coordination, maximising existing services, infrastructure, workforce and technology. PHNs are encouraged to be innovative in the design of clinical care coordination models that will meet the needs of their region, within the bounds of relevant programs and legislation, and with optimal links to the private sector, state services and psychiatry services.

Why is this a priority activity for PHNs?

In line with a stepped care approach to mental health, there is a need to ensure that the level or service provided to people with a severe mental illness is matched to their presenting needs. A stepped care approach will improve the service response to people with more severe and complex forms of mental illness. Primary mental health care service options previously available have been inadequate to support full recovery and/or optimal functioning for these people as well as reduce further escalation and the need for more complex and resource intensive intervention. More flexible and innovative service approaches in the primary care setting are warranted, particularly for young people who may not currently be receiving optimal early intervention services.

Fragmentation of care is particularly problematic for people with severe and complex mental illness who often have to navigate a complex system across multiple health and other service providers. Duplication and role confusion between governments has also been noted.

Data suggests that between 2 and 5 percent of Better Access users seek support from the initiative year in and year out, suggesting they have an enduring and severe form of mental illness which could potentially be better addressed through an alternative service delivery model.

How should PHNs implement this priority?

In 2016-17, implementation of primary mental health care services for people with severe mental illness should focus on the following:

- identify existing services for people with severe mental illness in the region through their regional mental health plans;
- identify service gaps for people with severe mental illness, including those with complex needs, and develop a plan for commissioning clinical services;
- develop partnerships with regional stakeholders, state and territory services, private sector organisations and NDIS providers. Close consultation with states and other services to establish systems and process to support service integration within a stepped care approach will support implementation of this priority area;
- commission mental health nursing services from existing providers of the MHNIP to ensure service continuity to existing MHNIP clients and to ensure the services focus on clinical care coordination;
- commission new mental health nursing services with allocated growth funding in regions with current mental health nursing service levels below the weighted national average;
- develop service models for young people with, or at risk of, severe mental illness;
- promote the importance of management of the physical health of people with enduring severe mental illness;
- explore the non-clinical services available in the region, including the NDIS but also other mainstream services to support people with severe mental illness. While PHNs cannot commission psychosocial support services from the flexible primary mental health funding pool, they should promote links and pathways between clinical services and broader support services;
- provision of information to service providers on these available services to support integration around the needs of individuals; and
- engage with private psychiatrists in the region to ensure best use of psychiatrist services within a stepped care approach. This could include encouraging psychiatrists to support management of people with severe mental illness by GPs and psychologists, where this is appropriate, thereby improving and increasing access to appropriate mental health care.
 - For instance, PHNs could promote more effective use of existing consultant psychiatrist MBS items for GP referred psychiatrist assessment and management plan and review (MBS Items 291 and 293) and initial psychiatrist consultation items (MBS items 296, 297 and 299).

- PHNs could also promote the use of Telepsychiatry services as an effective, evidence-based mechanism to increase access to high quality clinical services (MBS Item 288).

PHNs that are managing Partners in Recovery and/or Day to Day Living programs in their regions from 1 July 2016 under arrangements outside the flexible funding pool need to factor these programs into their regional mental health planning and service commissioning.

In the longer term, over the three year implementation period, implementation should focus on the following:

- develop regional based clinical assessment processes to supplement and assist the role of GPs and facilitate appropriate referral pathways to non-health services through the NDIS
- commission services over and above what is currently available through the MBS that does not sufficiently meet the clinical needs of people with severe mental illness. This could include, for example, additional sessions beyond the 10 sessions available under the Better Access initiative;
- develop and implement models to provide clinical care coordination for individuals with severe and complex mental illness. This could, for example, involve a clinical assessment process, allocating a clinical care coordinator to the consumer to support attendance at clinical appointments; and
- promote the use of single care plans and single digital health records to link services and enhance communication between providers and people with mental illness, particularly those with severe mental illness and complex needs who may have multiple providers involved in their overall care.

Mental health nursing services

With regard to funding for mental health nursing services, 2016-17 is a transition year. Continuity of care to existing clients accessing services on 30 June 2016 is paramount. PHNs are therefore expected to commission mental health nursing services via the current network of MHNIP providers in 2016-17. From 2018-19 mental health nursing funding will transition fully to the flexible funding pool.

Funding available for mental health nursing services in 2016-17 is commensurate with 2015-16 funding. Additional funding has also been allocated in regions that currently have service levels that are less than the weighted national average. From 2017-18 PHNs will be required to use detailed regional planning and needs analysis to inform service distribution to ensure mental health nursing services are available where required across the region. This may be through existing or new providers.

From 2017-18 funding allocations will be redistributed across all regions based on a population funding model designed to promote better equity and that takes account for a range of sociodemographic factors known to impact on population need for mental health care. This will result in funding increases in some regions and decreases in others. The Department will work with relevant PHNs to manage the impacts effectively.

Young people with or at risk of severe mental illness

A priority short term activity for PHNs is development of service models for young people with, or at risk of, severe mental illness. Further detail on these arrangements will be provided in the near future, together with information about transition arrangements for Early Psychosis centres funded by the Commonwealth.

What national support will be available for local implementation?

Lead PHN sites will develop and demonstrate innovative models for funding packages of care for people with severe and complex mental illness. These lead sites will share their findings across the national PHN network to inform full national roll out.

How can the PHN ensure they are commissioning value for money services?

PHNs are not required to charge consumers a co-payment for services. However, in commissioning primary mental health services, PHNs will need to determine their own consumer co-payment policies and guidance for service providers that take into account the characteristics of the population, including capacity to pay for services.

The Department is developing further advice on service quality and value for money.

Remuneration of mental health nurses should be in line with industry standards (refer to *Useful Resources* section). PHNs can leverage off 'shared employment arrangements' with state and territory health organisations to maximise the potential of the existing mental health nurse workforce, particularly in rural and remote areas.

Definitions

Please refer to the stepped care guidance document for definitions of mental health problems, mental illness and severity of mental illness.

Mental Health Nurse

Mental health nursing is a specialised field of nursing which focuses on working with clients to meet their recovery goals. Mental health nurses consider the person's physical, psychological, social and spiritual needs, within the context of the person's lived experience and in partnership with their family, significant others and the broader community.

Mental health nurses support clients and their families during life crises and transition periods. They liaise discretely and effectively with a range of health care providers, provide information and education on mental health maintenance and restoration, coordinate care and provide talking therapy.

Mental health nurses work across the full range of clinical and service settings and across metropolitan, regional, rural and remote areas – they play a significant role in the health care system and have the qualifications, skills and experience to provide high quality mental health nursing care in all contexts. The mental health nursing workforce needs to be flexible and responsive and able to work with people across the life span, and in a variety of work place settings.

Severe mental illness

Severe mental illness is characterised by a severe level of clinical symptoms and degree of disablement to social, personal, family and occupational functioning. An estimated 3.1% of the population have severe disorders, equivalent to 690,000 people. About one third of the severe group have a psychotic illness, primarily schizophrenia or bipolar disorder. The largest group (approximately 40%) is made of people with severely disabling forms of anxiety disorders and depression.

Severe mental illness is often described as comprising three sub categories:

- Severe episodic mental illness – refers to individuals who have discrete episodes of illness interspersed with periods of minimal symptoms and disability or even remission. This group comprises about two thirds of all adults who have a severe mental illness.
- Severe and persistent mental illness – refers to individuals with a severe mental illness where symptoms and/or associated disability continue at high levels without remission over long periods (years rather than months). This group represents about one third of all adults who have a severe mental illness.
- Severe and persistent illness with complex multiagency needs –the most disabling of the severe category requires significant clinical care (including hospitalisation), along with extensive support from multiple agencies to assist in managing most of the day to day living roles (e.g. housing support, personal support worker domiciliary visits, day program attendance). This group is relatively small (approx. 0.4% of adult population, 60,000 people) and is the group targeted for Tier 3 packages under the NDIS.

For the purpose of this paper, the concept of ‘severe and complex mental illness’ is not aligned directly to any one of the above three groups. A proportion of all three groups may have complexities associated with their mental illness that require additional services and care. Complexities can include medical comorbidities such as a chronic illness that causes disability, high risk for suicide (which may occur for example in those with severe episodic illness) or the need for coordinated assistance across a range of health and disability support agencies.

Useful resources and information

Resources

- National Standards for Mental Health Services 2010
<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-servst10>
- National Practice Standards for the Mental Health Workforce 2013
<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-wkstd13>
- The Department of Health and Ageing’s *Evaluation of the Mental Health Nurse Incentive Program*
<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-e-evalnurs>
- The Australian College of Mental Health Nursing
<http://www.acmhn.org/>

- *Nurses' Paycheck* for information on industry standards for nursing remuneration (available by subscription from the Australian Nursing and Midwifery Federation)
- Those PHNs not previously involved in the delivery of MHNIP services may wish to look at the 2015-16 MHNIP Guidelines for further background on how MHNIP services have been delivered in the past, noting the flexibilities available under the new arrangements. See the Tools and Resources information at <http://www.health.gov.au/phn>
- Information on clients and service characteristics at the local level is available through the PHN portal, including the secure portal.
- The role of the psychiatrist (RANZCP 2013) https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-80-PPC-Role-of-the-Psychiatrist.aspx
- Find a psychiatrist
 - RANZCP online database: Search for consultant psychiatrists in Australia by location, specialty, gender, services and more <https://www.ranzcp.org/Mental-health-advice/find-a-psychiatrist.aspx>
- Best practice referral, communication and shared care arrangements between psychiatrists, general practitioners and psychologists (RANZCP 2014)
 - This guideline aims to assist communication flow, clarification of patient management, patient care and safety. It outlines steps for best practice in referral, communication and shared care agreements between the GP, psychologist and psychiatrist https://www.ranzcp.org/Files/Resources/College_Statements/Practice_Guidelines/P5-Best-Practice-Referral-Communication-between-ps.aspx
- Keeping Body and Mind Together, Improving the physical health and life expectancy of people with serious mental illness <https://www.ranzcp.org/Files/Publications/RANZCP-Keeping-body-and-mind-together.aspx>
- Find a psychologist
 - An Australian Psychological Society resource which enables a search for psychologists to be filtered by issue, location, client type, gender, languages and more http://www.psychology.org.au/FindaPsychologist/?utm_source=Homepage&utm_medium=Sidebar%2BTile&utm_campaign=FaP

What is the role of mental health nurses?

- It is expected that mental health nurses will work with general practitioners and/or psychiatrists to provide coordinated clinical care for people with severe and complex mental illness. This care will be delivered in line with a GP Mental Health Treatment Plan or equivalent, developed by the GP or psychiatrist.
- It is expected that mental health nurses will provide a range of services including:
 - agreed clinical care within the scope of practice of the mental health nurse in accordance with the agreed collaborative treatment plan;
 - monitoring a client's mental state;
 - liaising closely with family and carers as appropriate;
 - administering and monitoring compliance with medication;

- providing information on physical health care, as required and, where appropriate, assist in addressing the physical health inequities of people with mental illness; and
 - improving links to other health professionals/clinical service providers.
- These may be delivered face to face or via telephone depending on client needs.
- The focus of these services is on clinical support and is not designed to provide psychosocial support to clients.
- The ultimate aim of clinical care and coordination delivered by mental health nurses is to support clients to effectively manage their symptoms and avoid unnecessary hospitalisation.
- It is expected that the mental health nurses engaged demonstrate that they have the appropriate skills and experience required. This may be through individual assessment by relevant employers/contractors or through acceptance of the credentialing offered by the Australian College of Mental Health Nurses (ACMHN). Participation in the ACMHN program by mental health nurses is voluntary.
- It is expected that mental health nurses funded through the flexible fund to work with people with severe and complex mental illness should be, at a minimum, Registered Nurses with specialist mental health nursing qualifications and experience, and eligible for membership of the Australian College of Mental Health Nurses (ie Registered Nurses working in the field of mental health). However, they are not required to be members of the College.
- These mental health nurses will require a broad range of skills to perform their role effectively. It is expected that they will have knowledge and experience in the following specific areas:
 - establishing a therapeutic relationship
 - mental health assessment and monitoring
 - clinical care and treatment planning
 - risk assessment and monitoring
 - pharmacology
 - psycho-education
 - physical health care
 - awareness of health care environment and other services
 - treatment team coordination, supervision and case discussion
 - health promotion and coaching
 - contributing to the clarification of diagnosis
 - pre and post outcome monitoring
 - collaboration with clients, carers, stakeholders to develop partnerships.
- The scope of practice for a mental health nurse is founded on the *RN Standards for Practice (NMBA)* and the *National Decision Making Framework*.
- Guidance on specific mental health nursing capabilities should be based on both the *ACMHN Standards of Practice for Mental Health Nurses 2010* and the Department of Health's *National practice standards for the mental health workforce 2013*.

Learnings from Partners in Recovery (PIR) and Day to Day Living (D2DL) Organisations

- Many PIR Organisations have undertaken needs assessments to support implementation of the program in their regions. PIR Organisations have also undertaken a wide range of systems reform and capacity building activities across sectors providing services to people with severe and persistent mental illness. D2DL

Organisations also play an important role in facilitating access to various services and supports for program clients. It will be important for PHNs to engage with PIR and D2DL service providers to understand the clinical needs of the client group, particularly over the next three years as clients are transitioned to the NDIS.

Rollout of the National Disability Insurance Scheme

- National rollout of the NDIS commenced on 1 July 2016, with full rollout to be achieved by 30 June 2019. PIR and D2DL programs will be extended for three years to ensure service continuity during the transition period and to support NDIS roll out. After the transition period, in-scope funding will be transferred to the NDIS.
- A number of PIR and D2DL Organisations are participating in NDIS trial sites. Data from trials and the national rollout will inform transition, as well as broader work on the NDIS/mental health interface.