

Reform and System Transformation:
A Five Year Horizon
for PHNs

September 2018

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- National Aboriginal and Torres Strait Islander Leadership in Mental Health
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Acronyms and Abbreviations

Term	Definition
ACCHS	Aboriginal Community Controlled Health Service
ACSQHC	Australian Commission for Safety and Quality in Health Care
AoD	Alcohol and other Drugs
ATAPS	Access to Allied Psychological Services
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
Commission	National Mental Health Commission
DoH	Department of Health
DVA	Department of Veterans Affairs
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
GP	General Practitioner
KPI	Key Performance Indicator
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
LHN	Local Hospital Network (District)
MBS	Medicare Benefit Scheme
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGOs	Non Government Organisations
NSQHSS	National Safety and Quality Health Service Standards
Panel	Primary Health Network Advisory Panel on Mental Health
PHN	Primary Health Network

Introduction

Achieving better mental health outcomes for consumers through access to the right care, at the right time in the right place is fundamental to mental health reform and system transformation. Primary Health Networks (PHNs) have been tasked with a key role in driving mental health reforms in Australia, as commissioners of primary care mental health services. In this role, PHNs have also been positioned to enhance the regional integration of mental health services.

The PHN Advisory Panel on Mental Health (the 'Panel') was established by the Minister for Health, the Honourable Greg Hunt MP, to provide advice on the progress of the role of PHNs against the current mental health reform journey. The Panel has been requested to provide recommendations to further guide and support PHNs in the transformation of the mental health system.

The Panel has overseen an extensive national consultation process, conducted by EY, that encompassed a range of PHN stakeholders including executives, and commissioning and mental health portfolio leads. The consultation process also involved listening to consumers and carers with lived experience, as well as community leaders. The Panel has also considered national and global leading practice in mental health commissioning, to strengthen the utility and sustainability of the reform journey.

This comprehensive program of work has enabled the Panel to develop a five year transformation approach that will resonate with the needs and expectations of mental health consumers. This has centred primarily, but not exclusively, on the role and expectations of PHNs, as other stakeholders in the mental health sector must also take action if the required reforms are to be successful. True system transformation requires all stakeholders of the mental health sector to consider their role within the policy and operating context to determine how they may need to evolve and transform to achieve the best collective outcomes for mental health consumers.

To support the scale of transformation that is required over the next five years, the Panel has led the development of this strategic document: *Reform and System Transformation – A Five Year Horizon for PHNs*. It articulates a vision for the mental health reform to be implemented by PHNs over the next five years and will serve as a guide for PHNs in their roles as commissioners of primary care mental health services and as a system integrator. It recognises that PHNs cannot achieve mental health reform and system transformation on their own, and that all stakeholders within the complex mental health and social care system have a role to play.

Key to achieving system transformation is the development of strong regional partnerships that underpin and facilitate regional needs assessment and planning. Co-design with consumers and carers is essential, as is engaging with clinicians and service providers and the broader community. Building a regional health intelligence capability, with access to relevant local and regional data, will facilitate more accurate needs assessment and planning, and greater capacity to assess the impact and outcomes of commissioned services.

A new approach to commissioning is required, one that moves beyond traditional procurement methods to take into account regional markets and workforce considerations, along with a clear commitment to engaging with regional stakeholders through all phases of commissioning.

Delivering services across the spectrum of illness severity to meet the needs of individuals when and where they need care is a key aim of the stepped care approach that has been embraced by PHNs. In addition, achieving truly person centred care that takes account of the consumer's holistic needs is an additional goal.

The safety and quality of care must also be assured by appropriate clinical governance systems and compliance with recognised standards. A skilled and culturally competent workforce is necessary to achieve all of the above but there are currently many challenges in achieving the workforce that is needed, particularly in rural and remote areas.

The mental health system transformation outlined above is discussed across six domains in this document. The six domains are:

1. Engaging, Listening and Acting
2. Regional and Local Planning
3. Mental Health Commissioning
4. Person Centred Care
5. Safe and Quality Care
6. Working with Aboriginal and Torres Strait Islander Services and Communities

Progress indicators and actions for PHNs and other identified stakeholders are also set out to support the achievement of better outcomes for mental health consumers.

Policy and Operating Context

The National Mental Health Commission (the Commission) released their review, *Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services*, in November 2014.¹ The review detailed the urgent need for significant change across mental health services in Australia. Despite previous national consultations, planning processes and considerable changes in Commonwealth, State and Territory mental health policy over the last three decades, the review identified a system that is not appropriately integrated, with evidence of fragmentation and siloing of services and programmes. Consumers experiencing mental illness were found to be unable to consistently access the appropriate level of support, resulting in a negative impact on their wellbeing and level of participation in the community. The review commented that the mental health system does not see the whole person and responds too late. Overall, it noted that people with lived experience, families and support people have a poor experience of care.

The Commission concluded that:

“instead of a mental health system, which implies a planned, unitary whole, we have a collection of often uncoordinated services that have accumulated spasmodically over time,

*with no clarity of roles and responsibilities or strategic approach that is reflected in practice*¹²

The Commission advocated for extending the scope of PHNs to provide the regional architecture for equitable planning and commissioning of mental health and suicide prevention programmes, services and integrated care. It also recommended the implementation of a person-centred stepped care approach to mental health service delivery that empowers consumers and better supports self-care. In their response to the Commission's Review,³ the Australian Government committed to strengthening and extending the role of the newly established PHNs to provide a regionally driven approach to mental health services, through their intrinsic local community knowledge and developing commissioning capability.

The 'Fifth National Mental Health and Suicide Prevention Plan' (the 'Fifth Plan') was endorsed by the Council of Australian Governments ('COAG') Health Council in August 2017.⁴ The Fifth Plan has committed all governments to work together to achieve regional integration in planning and service delivery for mental health and suicide prevention services. Fundamentally, it also mandates that consumers and carers must be central to the planning, delivery, evaluation and continuous improvement of mental health and suicide prevention services.

These national mental health and suicide prevention reviews and plans have come at a time of considerable change in social policy in Australia, including the establishment of the National Disability Insurance Scheme (NDIS), which includes supporting consumers with severe psychosocial disability as a target population. The interface with the NDIS must be considered as the mental health reforms are being implemented through PHNs. Appropriate linkages to alcohol and other drugs (AoD) services also need to be considered in planning and implementing mental health reform.

PHNS as a Stakeholder in a Broader Mental Health System

PHNs are a key focus of the Australian Government for the implementation of mental health reforms, encompassing prevention through to early intervention, treatment and recovery services.

PHNs manage approximately 10% of the Australian Government's expenditure on mental health, as illustrated in Figure 1.

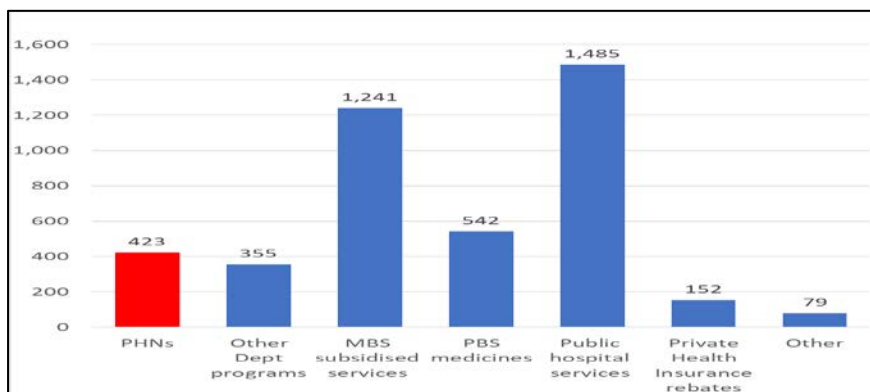


Figure 1: Commonwealth 2017/18 funding on PHNs including flexible funding
Source: Australian Government Department of Health

Approximately 60% of PHN mental health funding is attributed to the flexible funding pool (see Figure 2). The remainder of the funding is linked to nationally prescribed commitments. This includes funding for 'headspace' services, early psychosis youth services, Aboriginal and Torres Strait Islander mental health, suicide prevention services, trial sites and 'Partners in Recovery' transition funding.

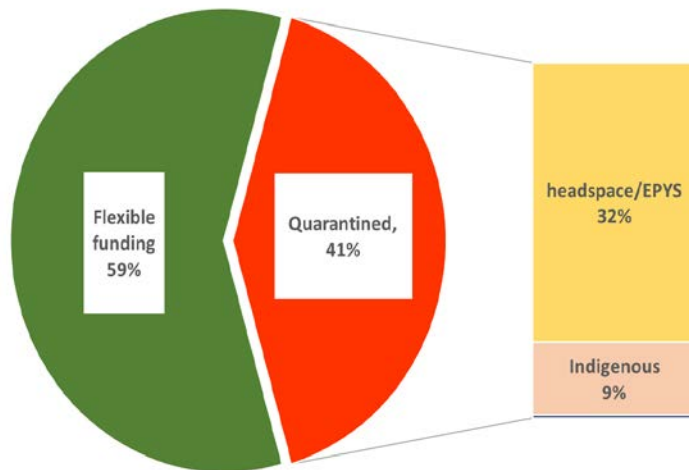


Figure 2: Allocation of PHN funding in 2017/18
Source: Australian Government Department of Health

Noting that PHNs have a role in providing services across the full spectrum of illness severity, their predominant responsibility relates to mild to moderate mental illness. There are many stakeholders and service providers within the complex mental health and social care system in Australia, with PHNs being only one of the stakeholders. Governance of the mental health and social care systems is also complex as it crosses all tiers of government as well as multiple sectors and portfolios. Figure 3 demonstrates the policy and operating context and the complexities of the mental health system in which reform must take place. This includes the interaction between the service delivery landscape, and multi-sectoral, multilayered government departments, organisations and funding streams.

PHNs alone cannot achieve reform of the entire mental health system. All service sectors and stakeholders (including general practice, public and private sectors, community managed organisations and Aboriginal Community Controlled Health Services (ACCHSs) must also contribute to the reform process.

Through the development of stronger partnerships and shared regional plans, PHNs can potentially influence reform across the entire mental health sector. This will take time, both to achieve the shared vision at a national and regional level, and to catalyse the changes necessary to achieve more integrated services and better outcomes for mental health consumers.

It is therefore essential to clearly articulate what PHNs can and should reasonably achieve within a five-year horizon. A pragmatic and reasonable approach should be applied to what

is expected of PHNs and what is achievable, within the resourcing and capacity available to them, and taking into account the policy and operating context.

It is also important to acknowledge the opportunities and challenges that a regionally devolved primary care model presents, and to consider the competing tensions that this approach presents.

PHN Role and Mandate

As commissioners and system integrators in the midst of mental health reform, PHNs have a role to:

- strengthen regional and local planning capabilities, that are driven by data and evidence based models of care
- enable the mental health system, primary care sector and communities to capitalise on opportunities for collaborative and conjoint commissioning
- facilitate the co-design of services through a genuine partnership approach throughout the mental health commissioning cycle
- mitigate identified gaps and mental health service inequities for target populations, including rural and remote and Aboriginal and Torres Strait Islander people
- deliver improved mental health outcomes driven through person centred care within the stepped care approach
- strengthen the safety, effectiveness and quality of mental health care, including clinical governance, standards and a culture of continuous improvement and learning
- incorporate a broader holistic approach to service delivery, including providing appropriate care to mental health consumers with physical illness
- in conjunction with the regional service provider network, identify workforce gaps and contribute to building workforce capability
- align commissioning processes and approaches to better integrate regional services and enhance the co-ordination of care
- minimise regional and national variability in outcomes, while supporting regional autonomy aspirations and needs
- reduce stigma and discrimination and the impact of mental illness

Finding the Balance

Each PHN is required to undertake a periodic assessment of their regional mental health and suicide prevention needs and to commission services in alignment with the stepped care approach. All mental health programmes and services that are commissioned should be based on the best available evidence. However, it is acknowledged that the evidence base may be limited or non-existent in some circumstances. Additionally, there may not be the economy of scale within a region to maintain fidelity to an established model of care that is evidence based but was derived to be applied in a larger urban setting.

Where a strong evidence base exists, the approach that PHNs take should reflect the strength of the evidence e.g. PHNs are required to commission headspace centres and observe fidelity to the headspace model as the evidence base is strong. This approach will see a level of consistency in services across the nation.

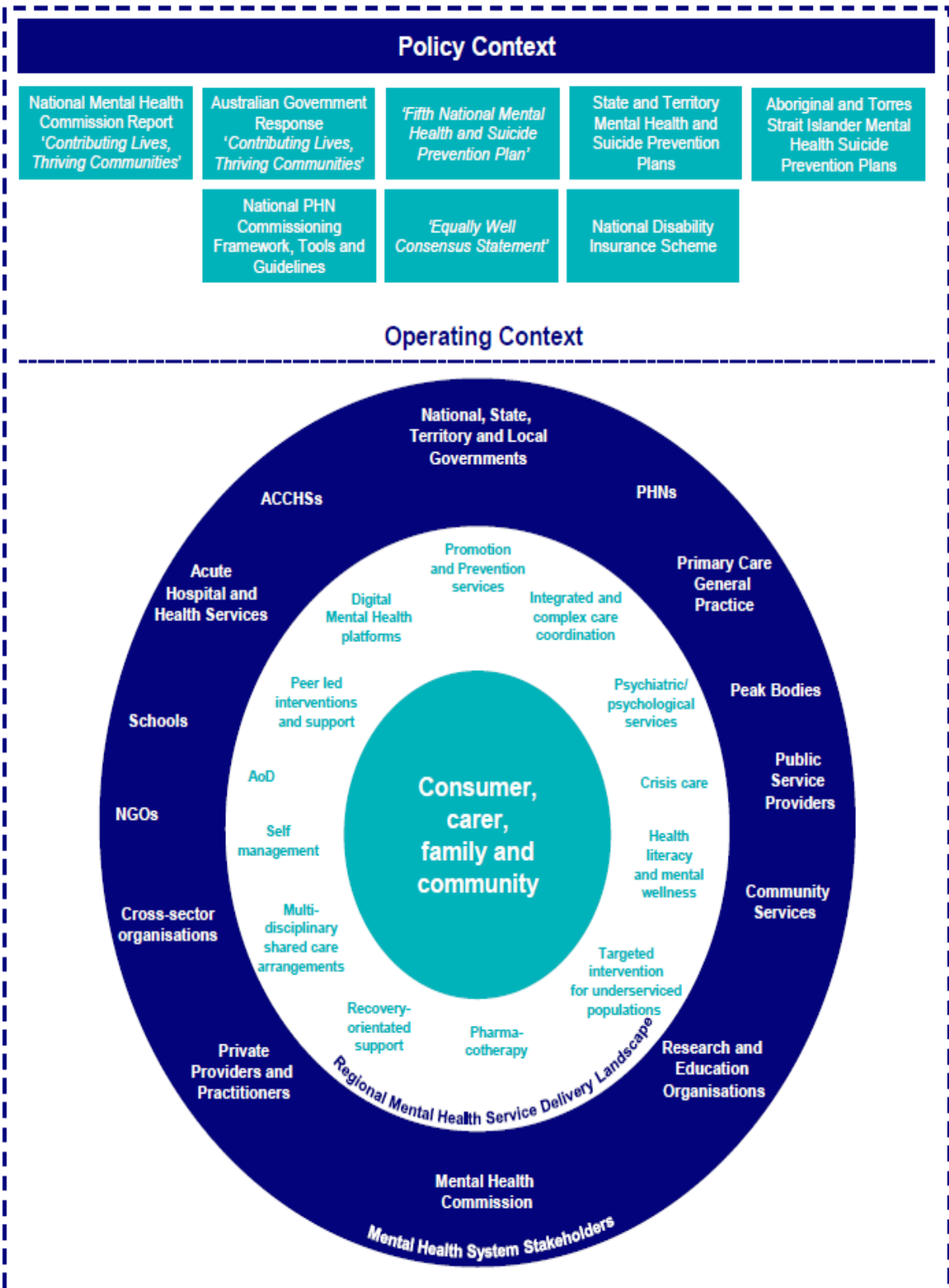


Figure 3: Australian Mental Health System Policy and Operating Context
Source: EY

Where there is limited evidence on which to base commissioning decisions, or where the population of the region does not provide the economy of scale required for fidelity to an established model, it is expected that greater variability in service models will occur, as each PHN works within their resources and those of their region, to develop innovative solutions to meet the identified needs of the region.

Given the variation in the needs identified across regions and the innovation necessary to meet needs where established national models don't exist, it is inevitable that there will be variability in the services commissioned by PHNs. This variability should not be automatically viewed in a negative light. In addition to reflecting a capacity to tailor services to regional need, it provides the opportunity for evaluation of different models of care. In practical terms however, it may mean that a consumer who moves across regions may need to access their care from a service with a different model of care, or they may even be unable to access a similar service in their new region.

It is evident from the above that balancing regional autonomy versus national consistency will be a challenge for PHNs in implementing reform. The tension between applying the established evidence base where it exists, and adding to the evidence base through innovation and evaluation where it does not, will be a consideration for PHNs. In weighing up these competing elements, PHNs need to maintain a focus on commissioning appropriate services that target their identified regional mental health and suicide prevention needs and deliver better outcomes for mental health consumers and carers.

A Note on the Future Role for Government

According to the Productivity Commission, government stewardship plays an important and ongoing role in the provision of human services. The Productivity Commission report⁵ noted:

- *Government stewardship - the range of functions governments undertake that help to ensure service provision is effective at meeting its objectives - is critical*
- *Stewardship includes ensuring human services meet standards of quality, suitability and accessibility, giving people the support they need to make choices, ensuring that appropriate consumer safeguards are in place, and encouraging and adopting ongoing improvements to service provision*

In this context, as PHNs mature, the Australian Government should be able to demonstrate the programmes, structures and systems it is maintaining:

- enables mental health services to meet appropriate standards for quality, suitability and accessibility
- builds the capacity of consumers and carers to make service choices
- embeds appropriate consumer safeguards
- supports ongoing improvements in service quality and the dissemination of leading practice.

1. Engaging, Listening and Acting

The Aspiration

Genuine engagement with stakeholders and the development of partnerships must underpin everything that PHNs do in advancing mental health reform.

Effective mechanisms to genuinely engage with all stakeholders are essential. All stakeholders need to be respected, acknowledged, listened to, valued and provided with appropriate opportunities to inform mental health programmes and services.

Stakeholders with whom PHNs must engage include consumers and carers, clinicians and service providers, and community members. Other relevant stakeholders may be peak bodies, academic leaders and national centres of excellence, depending on the programmes the PHN is commissioning.

Open and transparent communication is necessary to establish a regional vision that aligns strategic mental health priorities and develops a shared understanding of meaningful outcomes for consumers.

By listening to the voices of stakeholders throughout the mental health commissioning process, PHNs are better positioned to understand the holistic needs of consumers, carers, families and communities and to drive actions that respond to local and regional needs and capacities

Recognising that consumers with mental illness and their carers are experts through their lived experience, effective listening is important to:

- embed consumer centred principles into programme design
- incorporate genuine insights that drive innovation and integration across mental health services
- support effective implementation processes
- achieve meaningful mental health outcomes
- support the long-term sustainability and ongoing relevance of commissioned programmes and services
- optimise mental health outcomes by supporting the linkages of multi-sectoral approaches to target populations.

PHNs need to carefully consider and identify stakeholders that should be engaged, and focus on developing partnerships and trusting relationships, representing the diversity of consumers and carers. This includes children, youth and aged, as well as Aboriginal and Torres Strait Islanders, culturally and linguistically diverse (CALD) and lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ). PHNs need to utilise the right consumer voice, at the right time.

Genuine partnerships with communities can be facilitated through a range of engagement approaches including:

- PHN Community Advisory Committees
- collaborative workshops and feedback forums
- digitally enabled feedback mechanisms
- targeted community engagement campaigns

To commission evidence based and high quality services, PHNs also need to engage with and listen to clinicians and service providers to:

- drive service improvement
- provide safe and high quality care
- improve the consistency and performance of services
- break down silos across programmes and jurisdictions.

Formal mechanisms to engage clinicians and service providers should be established and include opportunities for their participation in all phases of the mental health commissioning cycle. Although PHNs are required to establish and maintain Clinical Councils, representation from mental health clinicians and service providers may be limited. A regional Mental Health Reference Group with representation from various primary and tertiary organisations is another option to guide commissioning activities.

The importance of developing effective partnerships cannot be underestimated but it takes time and requires a strong commitment and dedicated resources.

Progress Indicators and Actions

Consumer and Carer

Progress Indicator: PHNs utilise a structured approach to effectively engage consumers and carers to incorporate the right voice, at the right time			
Actions		Lead	Horizon
Action 1.1	Engage with consumers and carers, including those representing the diversity of the regional population, through appropriate structured mechanisms to identify local mental health and suicide prevention needs, preferences, meaningful outcomes and priorities	PHNs	1 year

Community

Progress Indicator: PHNs effectively engage their regional community to support improved mental health wellbeing and outcomes			
Actions		Lead	Horizon
Action 1.2	Engage with the regional community through appropriate structured mechanisms to capture population health needs, augment programme and service strengths, capitalise on opportunities, and to align preferences and priorities	PHNs	1 year

Clinicians

Progress Indicator: PHNs have a comprehensive approach to engaging clinicians to further understand the demand for mental health services, design of evidence based models of care, monitoring and evaluation processes and opportunities for innovation and continuous improvement.			
Actions		Lead	Horizon
Action 1.3	Engage with clinicians through appropriate structured mechanisms to enable professional expertise, validate population profiles and support the design of safe and high quality services that reflect the available evidence and likely success factors	PHNs	1 year

2. Regional and Local Planning

The Aspiration

Regional and local cross-agency planning is central to advancing and improving the regional mental health care delivery architecture, mental health reform and system integration.

In the absence of any authority over other regional and state-based stakeholders, it is essential that regional and local planning led by PHNs reflects a collective vision, built through a genuine process of co-design, consultation, partnership and use of data and evidence.

It is ultimately the collective impact of all stakeholders working together to achieve a common agenda, focused on the 'triangle of care' (see Figure 4 below) and using a structured collaboration platform, that will result in change and improvement.

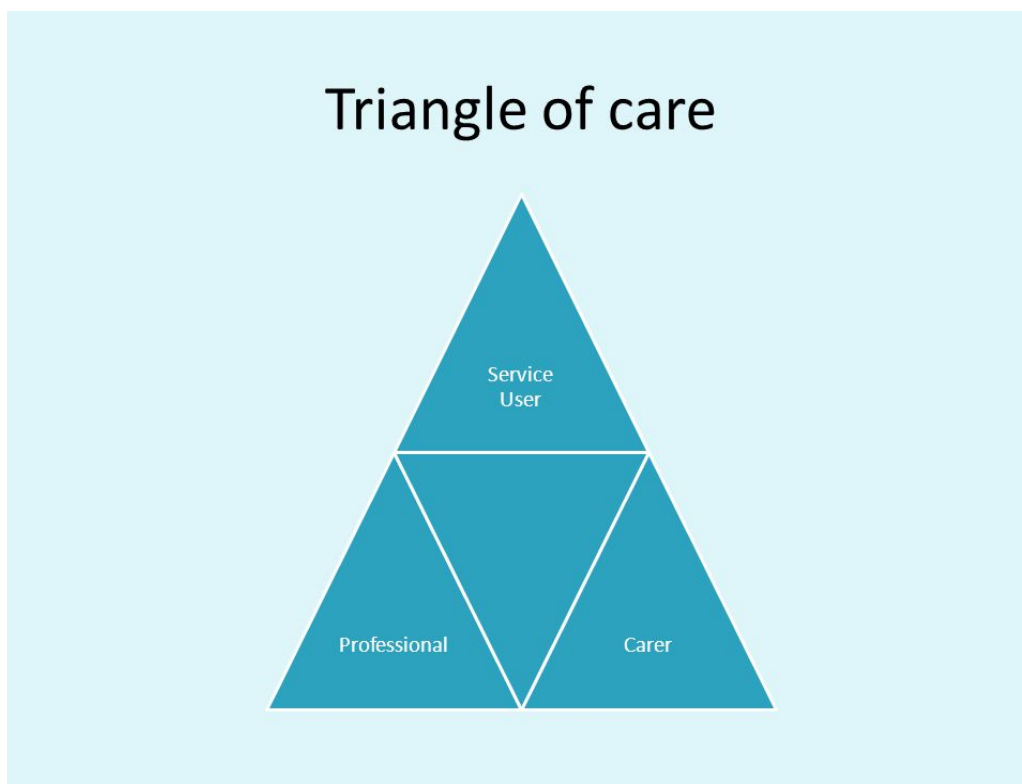


Figure 4: Triangle of care diagram

PHNs are well placed to ensure that the planning process is underpinned by partnerships with consumers, carers, families, clinicians, service providers and communities - especially hard to reach and disadvantaged communities such as rural and remote, Aboriginal and Torres Strait Islanders, CALD and LGBTI – and that it gives due regard to suicide prevention.

The PHN responsibility to lead the development of regional mental health and suicide prevention plans stems from the Australian Government's vision of PHNs as system integrators and commissioners of mental health programs and services. The Fifth Plan has

also seen all state and territory governments commit to this regional approach.

In this context, the role of the states and territories as system managers and the Local Health Networks in particular, cannot be overemphasized. It is vital that these agencies commit to actively engage and participate in regional and local mental health and suicide prevention planning.

Noting that the responsibility for reform rests with all agencies and not just PHNs, PHNs are well positioned as mental health change-agents to leverage their knowledge of the mental health needs of their population and the local service provider market. Integrated regional planning facilitates the alignment of local mental health services to provide the right care, at the right time, in the right place and by the right team.

Understanding the diversity of mental health needs and services in a region is integral to good planning. The regional mapping of mental health needs and services is necessary for effective co-design, reducing duplication, achieving better value for commissioned services, and addressing inequity and responding to the needs of the underserved and at-risk populations.

While PHN regional variations should be recognized in the planning approach, adherence to a consistent national framework, as far as possible, is essential. To this end, the use of the Fifth Plan, as a structure and framework, is encouraged.

It is anticipated that by 2023, consistent, collective and sophisticated regional and local mental health and suicide prevention planning will have emerged in all 31 PHN regions in Australia.

The Fifth Plan has also seen all governments commit to the Equally Well Consensus Statement⁶ which advocates for a holistic, person-centred approach to physical and mental health and well-being.

Taking a holistic view of health is essential in the planning process as mental illness is often associated with wider physical, social, cultural and economic determinants of health. For example, a mental illness may require a range of different interventions and supportive approaches at different times in the life of the consumer.

Mental illness may also be associated with a higher prevalence of alcohol and drug use, homelessness, domestic violence and unemployment, reinforcing the need for broad based interventions and systems thinking. Strategies and approaches that increase the community's social cohesion and assets have proven to be effective in contributing to a consumer's recovery and ability to lead a healthy and fulfilling life.⁷

In addition to a holistic view of the person and addressing the social and behavioural determinants, the use of data, strategic partnerships and appropriately trained and readily available workforce are necessary to support effective regional and local planning.

Data and Evidence

PHNs need appropriate access to mental health data from local, state/territory, national and global sources to gain a complete view of regional mental health need. Utilisation of these data sets will enable more effective planning and commissioning practices, and enable PHNs to target at risk populations and address gaps. In Australia, there are rich information datasets at the national and state levels. However, this unfortunately is not consistently the case at regional and local levels, making planning and commissioning processes challenging. PHNs need to take a lead role in supporting the collection and use of regional and local data, including data from primary health care and Aboriginal Community Controlled Health Services.

To establish a more sophisticated regional health planning and intelligence function, PHNs need to strengthen formal data sharing agreements and have appropriate resourcing and infrastructure. The application of robust analytical processes and key findings from the needs assessment will support identification of the characteristics and mental health priorities for the region.

Partnerships and Collaboration

PHNs need to collaborate effectively through strategic and structured partnerships with a range of stakeholders in order to integrate the multiple mental health and suicide prevention funding streams and systems. Strengthening regional mental health planning processes will enable PHNs to target investment decisions and commission appropriate programs that elicit greater outcomes for consumers, reduce inequity and address gaps.

Diverse accountability lines, agreements, funding streams and organisational Key Performance Indicators (KPIs), can make strategic regional partnerships challenging. Formalised governance structures are required to optimise partnerships to enhance the penetration, quality, integration and effectiveness of services. Regional mental health stakeholders, including LHNs and ACCHSs should be required and incentivised to participate in planning processes.

Regional readiness to adopt progressive commissioning approaches requires strengthening of the existing partnership at regional, state and national levels and mature regional planning capabilities. Investment needs to be made to build the capacity of service providers to participate in planning and co-design processes.

Workforce

As PHNs take an increasing role in commissioning mental health services, appropriate consideration is required of the workforce necessary to deliver evidence-based, integrated and innovative models of care. In working with national and state and territory governments, and other mental health stakeholders, a joint approach is required to the development of a diverse, suitable and skilled workforce, including peer-workers. Approaches to ensure the ongoing up-skilling of the mental health workforce are also required.

Additionally, PHNs need to build further capacity to stimulate the provider market so that a range of services and agencies are appropriately positioned to deliver sustainable, quality and safe care. The mitigation of workforce and service gaps is essential to improve the services delivered across the stepped care approach. Collaboration with the tertiary education sector, as well as national and state peak bodies may be required.

General Practices have a pivotal role in providing person centred and holistic care. PHNs need to work alongside General Practices and other clinical and community service organisations to support the regional integration of services. A structured process for PHNs to share experiences and lessons in workforce development, planning and innovation, as part of wider national, state, territory and local networks, will also be necessary.

Progress Indicators and Actions

Regional and Local Planning

Progress Indicator:		Lead	Horizon
Regional Mental Health and Suicide Prevention Plan developed, and implemented, in partnership with consumers, carers, families, clinicians and service providers, communities, Local Hospital Networks (LHNs), general practice, local government and other stakeholders			
Actions		Lead	Horizon
Action 2.1	Develop appropriate strategic and operational governance and advisory structures that foster genuine partnerships and collaboration to develop regional plans <ul style="list-style-type: none"> Enact agreements to formalise the planning and implementation processes for mental health and suicide prevention e.g. through Memorandum of Understanding, statements of intent, terms of reference or service level agreements 	PHNs	2 years
Action 2.2	Review regional governance arrangements to assess inclusiveness and the reflection of local diversity	PHN	2 years
Action 2.3	Undertake a regional mental health needs analysis to inform local service demand and identify gaps. This should include: <ul style="list-style-type: none"> local prevalence projected mental health care demand profiles, including emergency department presentations, admitted patient hospitalisation, suicide rates, self-harm rates, MBS care plan numbers, etc. 	PHN	2 years

	<ul style="list-style-type: none"> regional population mental health needs by geography, age, gender and underserved target population groups 		
Action 2.4	Consider the broader holistic needs of the consumers in the development of mental health and suicide prevention plans and commissioned services, including strategies to enhance social cohesion	PHNs	2 years
Action 2.5	Collaboratively plan and commission, evidence-based models of care that are designed to target and increase access to mental health services for the regional population, including rural and remote, Aboriginal and Torres Strait Islander, CALD, and LGBTIQ populations	PHNs	3 years
Action 2.6	Establish a transparent learning culture to identify and share lessons learned and examples of leading mental health commissioning practice throughout the regional planning process	PHNs Commonwealth DoH	5 years

Data and Evidence

Progress Indicator:			
PHNs and regional stakeholders have access to, and utilise, timely and reliable evidence, information and data for planning and commissioning purposes			
Actions		Lead	Horizon
Action 2.7	Develop data sharing arrangements with regional stakeholders to strengthen the regional health planning and intelligence function to better inform planning and commissioning processes	PHNs, LHNs, ACCHSs, State/Territory DoH, Commonwealth DoH	3 years
Action 2.8	Establish effective processes at national, state and regional levels to support all stakeholders to consistently capture, store, and report agreed mental health indicators - preferably in a single data repository	Commonwealth DoH State/Territory DoH PHNs	5 years
Action 2.9	Build capability to collect data and evidence to map funding flows into the region to service providers in order to understand total mental health expenditure and potential service duplication	Commonwealth DoH State/Territory DoH PHNs	4 years
Action 2.10	Establish a nationally consistent approach to support benchmarking and comparison of mental health indicators across PHNs (grouped into appropriate 'peer groups') and	Commonwealth DoH	5 years

	utilise and publish a standardised PHN mental health data dashboard to facilitate continuous improvement		
Action 2.11	Review reporting requirements to enable an appropriate level of accountability that does not detract from core business requirements	Commonwealth DoH PHNs	5 years

Workforce

Progress Indicator:			
In each PHN region, the Regional Workforce Strategy facilitates the availability of a diverse, suitable and skilled workforce, including peer-workers, and the ongoing up-skilling of the workforce			
Actions		Lead	Horizon
Action 2.12	Identify and collaborate with mental health stakeholders to develop a Regional Workforce Strategy. This should include exploring, in collaboration with mental health stakeholders, alternative workforce structures for delivering mental health programmes and services (Note: Regional Workforce Strategies could be guided by a National Workforce Development Strategy, once developed.)	PHNs, State/Territory DoH Commonwealth DoH	3 years
Action 2.13	Take systematic and collaborative steps, guided by the Regional Workforce Strategy, to enhance the capacity and capability of service providers to deliver services to mental health consumers and identify opportunities to embed the peer mental health workforce to augment the effectiveness of programmes and services	PHNs National and State Peak Bodies	4 years
Action 2.14	Support the workforce to develop capability to take advantage of emerging digital mental health platforms, especially in remote, rural and regional areas	PHNs	4 years
Action 2.15	Collaborate closely with mental health stakeholders to build the social and cultural competency of the workforce to provide appropriate care to Aboriginal and Torres Strait Islanders, CALD and LGBTIQ	PHNs	3 years
Action 2.16	Establish a structured process for PHNs to share experiences regionally and nationally in workforce development, planning and innovation	PHNs	5 years

3. Mental Health Commissioning and Decommissioning

The Aspiration

A new approach to mental health commissioning is at the core of the current mental health reforms.

PHNs are empowered to lead an approach to commissioning that is fundamentally different to the procurement approach utilised previously. PHN mental health commissioning is built on the following principles:

- Co-design: develop and design relevant and sustainable mental health services in partnership with consumers, carers, families and communities, national and local stakeholders, service providers and clinicians - at all stages of the commissioning cycle
- Commissioning and decommissioning: in accordance leading practice, implement models of care based on national and international evidence, while maintaining the integrity of regional strategic priorities and required services
- Partnership: PHNs are partners with local stakeholders, not simply government procurement agencies on a smaller scale, and will look to commission accordingly
- Integration: utilise commissioning processes that optimally leverage and link with other local services
- Market management: appropriately commission programmes through the stimulation of contestability in the service provider market, effective governance and robust probity processes

The new commissioning market will recognise that mental health services are not a pure commercial market. PHNs have an important role in fostering and shaping the service provider market to:

- build on local strengths
- support innovation while also providing stability
- achieve value for money
- enable good governance and transparency
- drive continuous quality improvement
- support the sustainability of services

Considerable international evidence to support a changed approach to commissioning was gathered in the report *Commissioning for Better Mental Health Outcomes*.⁸ This evidence supports commissioning arrangements that are most frequently characterised by 'high trust contracting' and consensus amongst co- design partners and stakeholders, rather than frequent tenders and other government-like procurement processes.

Outcomes based mental health commissioning represents an ideal which is largely yet to be realised. There are also challenges with this approach, including the need to define, agree and measure outcomes, the issue of the attribution of impact, and the risk of perverse incentives. The Panel recognises that a move towards funding that is more outcomes-oriented is desirable but acknowledges that a transition to outcome based commissioning

will take longer than the five year horizon projected within this strategic document. The shift in focus from activity to outcomes will be an iterative process over time and will require the entire mental health system to work collaboratively.

Mental Health Commissioning Cycle

The PHN mental health commissioning cycle (see Figure 5) provides the framework to achieve regionally appropriate services for consumers. Mental health commissioning is a continuous, iterative process that is comprised of four key phases:

- Phase 1: Needs assessment and planning
- Phase 2: Design of mental health services
- Phase 3: Sourcing and contracting
- Phase 4: Monitoring and evaluation

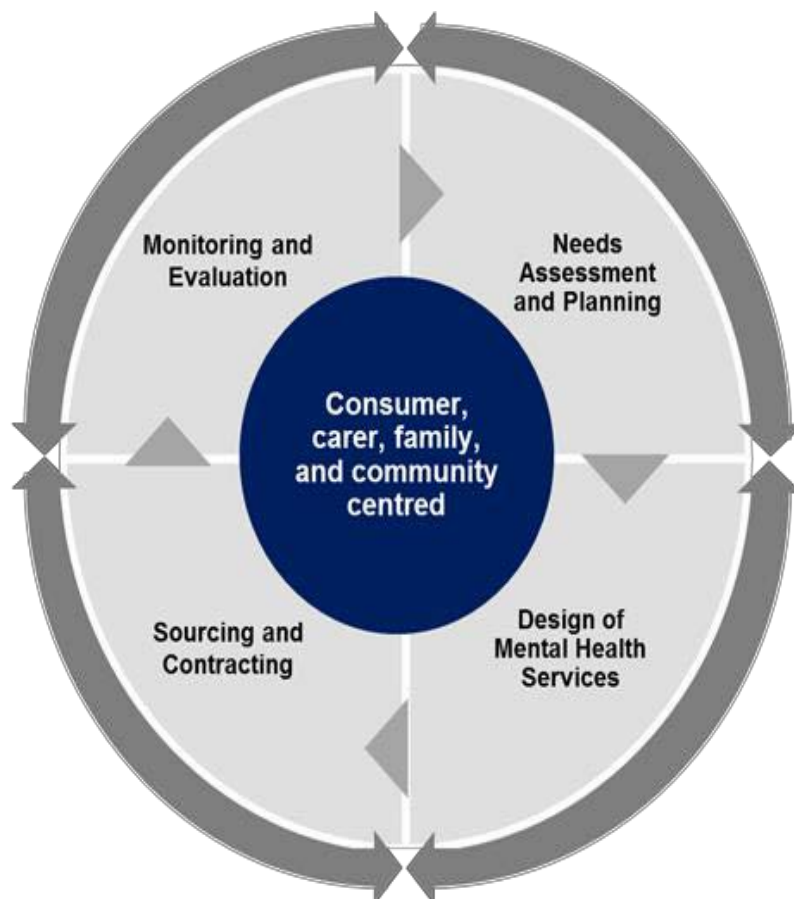


Figure 5: Mental Health Commissioning Cycle

Each of these phases is outlined below.

Phase 1: Needs Assessment and Planning

PHNs are required to develop a comprehensive understanding of the mental health needs of their community and target population cohorts. Mental health needs must be identified through robust analytical processes informed by consumers, carers, families, communities, clinicians and service providers. Epidemiological data, sociodemographic information and multi-sectoral indicators should be considered during the needs analysis and service mapping of mental health services. Utilising a holistic view of the consumer is essential as mental illness is often associated with wider physical, social, cultural and economic determinants of health.

The use of data and genuine partnerships as a mechanism to support regional and local planning is discussed in Chapter Two – Regional and Local Planning. Developing more detailed regional knowledge, will enable PHNs to identify nuances and trends in populations, understand gaps in current programmes and services, and determine the most effective configuration of services across the stepped care approach.

Phase 2: Design of Mental Health Services

The stepped care approach requires PHNs to consider how existing mental health programmes can be enhanced to provide appropriate needs based services. As commissioners, PHNs may need to trial emerging and innovative models of mental health care, co-designed with stakeholders. This approach is supported by the Australian Government Department of Health, which endorses the testing and piloting of innovative delivery models.⁹ PHNs should utilise external clinical and regional expertise and people with lived experience throughout the commissioning cycle.

The design of mental health services needs to consider:

- national service models, frameworks and standards
- national data collections and mental health trends
- regional and local variation
- safety and quality
- value for money and evaluation outcomes
- local service delivery capacity

Through this process, service specifications with transparent criteria can be determined, including defining the target geography or population of the programme or service. Critical implementation success factors can also be identified at this point.

PHNs need to appropriately consider the mental health needs of vulnerable and hard to reach population groups including rural and remote, Aboriginal and Torres Strait Islanders, CALD, and LGBTIQ.

PHNs also need to assess the cultural competence of a mental health service provider when making commissioning decisions, recognising the need for cultural alignment with particular population groups. Some organisations may have strong existing cultural links and competencies to enable successful work with particular population groups.

Consideration should also be given during co-design processes to defining measurable and meaningful outcomes for target population, value analysis and clinical governance mechanisms.

Phase 3: Sourcing and Contracting

The sourcing and contracting of mental health services requires a staged and planned approach. As commissioners, PHNs are accountable for the approach to market decisions, probity provisions, and procurement planning and contractual obligations. Many factors influence the sourcing and contracting of mental health services, including workforce availability, market maturity, specialised delivery requirements and the programme size and complexity.

PHNs need to ascertain whether a direct approach to single or multiple providers is required or whether an open market process is more appropriate. In regions of Australia where the diversity or maturity of the service provider market is not advanced, PHNs need to work closely with potential service providers to develop capability and capacity, to achieve the required mental health outcomes.

Contractual obligations need to be closely aligned to the service specifications and the regional operating context and may require leading approaches that include collaborative tenders, prime contractor, joint venture, consortia and sub-contractor models.

Contingent upon funding availability for PHNs, consideration must be given to what is the optimal period for contracts with service providers. Ideally, the period determined will allow for the continuity of services as well as for the appropriate review of the outcomes of the service prior to any decision about the next contract. Excessively long contracts can make the process of change, if required, more complex. A minimum lead time for any contract review decision provides the capacity to plan for any changes and safeguard continuity of care for consumers. This lead time should be no shorter than 6 months, and preferably 12 months notice would be given when possible.

Balancing contractual arrangements and regional need should be a continual process. PHNs should also support service providers in continuous improvement processes and opportunities for service innovation.

Phase 4: Monitoring and Evaluation

PHNs need to engage consumers, carers, families, communities, clinicians and service providers to monitor and evaluate the efficacy and effectiveness of commissioned mental health programmes. This practice includes managing service provider performance against a specified mental health outcomes framework, demonstrating value for money and supporting continuous improvement processes.

PHNs need to commission programmes that generate the best return on investment, with a focus on improving mental health outcomes and high quality service provision. Adopting standardised data collection is essential to the monitoring, evaluation and benchmarking of mental health programmes. To reduce duplication, improve efficiency and decrease administrative burden for reporting entities, a greater emphasis on single reporting structures is required.

PHNs may determine that it is appropriate to decommission a mental health programme or service. This should not come as a surprise when commissioning processes are conducted well across all four phases, as the decision to decommission will be transparent and perceived to be a natural outcome of this optimal process.

Regardless of the process to arrive at the decision to decommission a mental health programme or service, a robust and comprehensive transition plan is required to address the challenges associated with this process. The focus of transition plans are on effectively engaging with consumers, carers, families and communities and maintaining relationships with clinicians and service providers to sustain the continuity of mental health care services. Transitional plans need to be transparent, allowing sufficient time to manage the transition process effectively and to minimise the impact of service disruption on individual consumers, their carers and families.

In summary, the mental health commissioning is characterised as follows:

- Governance arrangements encompass the diverse expertise and interests of their regional community
- Local needs assessments affect the mix of services commissioned, by identifying the variation of local circumstances from other regions, in order to best address local need
- Commissioning is undertaken in partnership through co-design with consumers and carers, communities, clinicians and service providers
- Thorough local needs assessment allows adaptation of best practice models in order to better suit local circumstances
- National structures and processes support PHNs to incorporate service models that utilise leading national and international evidence
- Opportunities are leveraged to partner with state/territory and local government, and other local partners, to support better integration and coordination of services
- Commissioning processes are transparent and accountable
- Robust internal review and appeal processes are utilised
- Commissioning is informed by the ongoing exchange of evidence and knowledge
- Burden of compliance requirements is minimised, through efficient data collection and streamlined reporting processes

Integrated Care Pathways

PHN mental health commissioning needs to focus on creating an improved consumer experience, better outcomes and opportunities for recovery. This can be achieved by building care pathways, and linking local service systems. Recognising that PHNs do not commission the majority of mental health services within a region, PHNs need to partner with other funders and explore co-commissioning arrangements. Co-commissioning may include collaborative commissioning or conjoint commissioning.

Co-commissioning is essential to achieve the alignment of multiple funding streams and priorities, to integrate services across the stepped care approach and ultimately to improve the consumer experience and outcomes. Opportunities to integrate mental health services and programmes with other portfolios, such as AoD services, NDIS and aged care should be appropriately considered.

Conjoint commissioning across two or more PHNs by pooling budgets and resources may be considered when there are complementary mental health population needs identified across regional geographies. This approach can leverage the capabilities of service providers and support market efficiencies for the respective PHNs in the delivery of programmes and service, without compromising the need for regional and local co-design and appropriate consultation.

These emerging commissioning practices will further support the required reform and connect regional mental health resources by aligning multiple funding streams and priorities to integrate services across the stepped care approach. Through the strategic use of commissioning funds and the collaborative commissioning process, PHNs can maximise value for money and contribute to system transformation.

Progress Indicators and Actions

Mental Health Commissioning Cycle

Progress Indicator: PHN mental health commissioning and decommissioning reflects best practice, including the principles of co-design, partnership, integration, transparency and accountability			
Action		Leads	Horizon
Action 3.1	Develop service specifications based on the robust analysis of data and a commissioning approach that incorporates co- design, partnership and integration	PHN	3 years
Action 3.2	Routinely utilise consumers, carers, communities, clinicians and service providers in all stages of the commissioning cycle	PHNs	3 years
Action 3.3	Commission services to provide continuity for consumers and carers, stability and security of the workforce, continuous improvement and innovation	PHNs	3 years
Action 3.4	Utilise structured, comprehensive transition plans to support effective decommissioning practices including maintaining the integrity of regional services	PHNs	3 years
Action 3.5	Promote standardised, transparent and regular reporting to support continuous quality improvement	PHNs	4 years

Integrated Care Pathways

Progress Indicator:

Regional integrated care pathways are developed and available to regional service providers

Actions		Lead	Horizon
Action 3.6	Enhance regional integrated care pathways that provide a more seamless consumer and carer experience	PHNs	4 years
Action 3.7	Engage broader stakeholders and programmes, including AoD, social and community services, NDIS, DVA and State/Territory/local governments in the mental health commissioning cycle	PHNs	5 years

4. Person Centred Care

The Aspiration

PHNs will deliver a person-centred stepped care approach to mental health service delivery that empowers consumers and better supports self-care.

Person-centred care is a way of thinking and doing things that includes the people using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs. It puts people, and their carers and families, at the centre of decisions and sees them as experts, working alongside professionals to get the best outcome.¹⁰ Consumers are assisted to manage their treatment, through a partnership approach to their care needs and regular review of their care plans. Families and carers are included as partners, as they are a central part of a consumer's network and integral to their recovery.

The stepped care approach, outlined in Figure 6, sees an appropriate range of interventions made available across the continuum of care, with consumers supported to move fluidly between programmes, service providers and sectors as their needs change. Local planning and development must support pathways of care that provide a range of services to match the needs of consumers at any point in time.

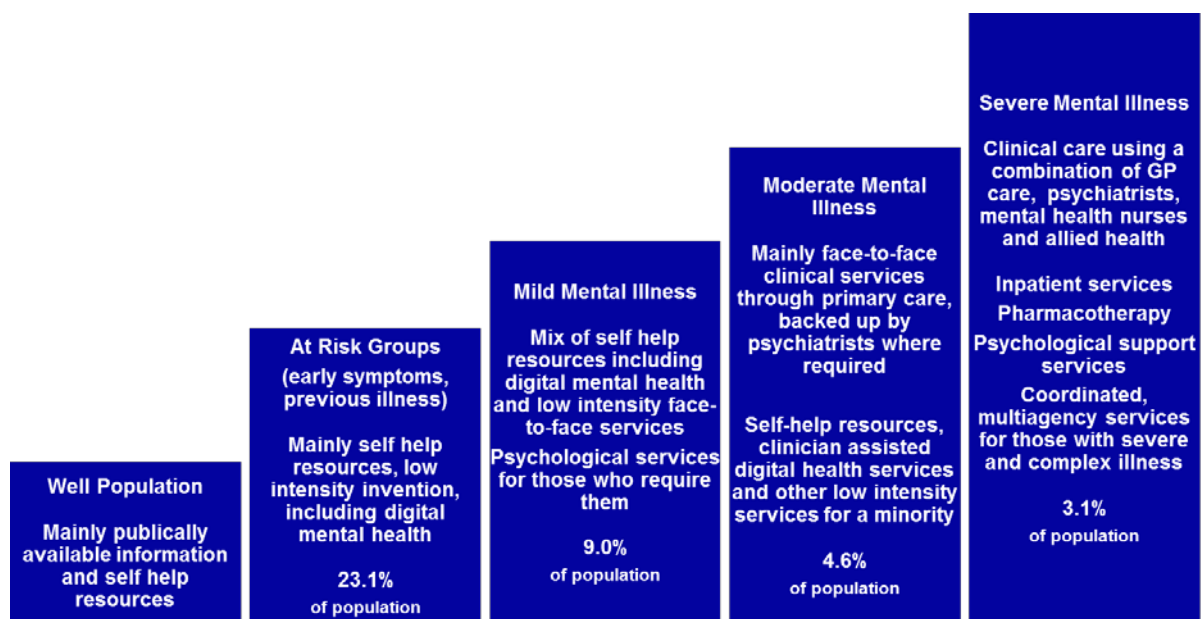


Figure 6: The stepped care approach

Source: The Fifth National Mental Health and Suicide Prevention Plan

Mental health consumers will often have a multidisciplinary team involved in their care. Strengthening the integration of care is critical so that accountabilities and responsibilities are understood and enacted by all stakeholders. Recognising that the needs of mental health consumers are often not appropriately managed through a 'one-size-fits-all approach,' person centred care is essential. The best outcomes will be achieved if each of those engaged puts the consumer at the centre. A process of cultural change is necessary to

achieve this, not only across the mental health system but also the broader health and social system.

As an individual's mental health status is impacted by the broader aspects of their life, developing an individual mental health plan should consider physical health, education, housing, personal goals and social circumstances. Person-centred care is therefore about adopting a social determinants and inclusive approach, and requires consideration of the individual's desires, values, family situations, social circumstances and lifestyles as well as their mental health status. It necessitates seeing the person as an individual, and working together to develop appropriate solutions.

Active participation of consumers in the decisions that affect their lives requires the sharing of information and opinions, alongside their carers and clinicians and service providers. It means joint problem solving, decision-making and responsibility. It therefore is as much about the way professionals and consumers think about care and their relationships as it is about the actual services that are delivered.

Changing the way clinicians function is an important consideration. They require the skills and competency to make the cultural shift to genuinely partner with consumers, carers and families.

This principle also applies to PHNs. They need to demonstrate the capacity and the capability to competently engage with consumers and carers and apply a genuine co-design approach.

A shift towards person-centred care is significant to the success of the reform journey. What is required is a cultural change process across the whole system, to change the mindset of PHN commissioners and health professionals and to empower consumers to control the care they receive. It is recognised that this change process is likely to extend beyond the five-year horizon of this strategic document.

In particular, changes are required across three key elements within the mental health system:

- Changes to the way clinicians function
- Increasing consumer and carer health literacy and empowerment
- System changes

The Way Clinicians Function

Changes must occur in the relationship between a clinician and the consumer - the professional expertise remains central, but is used to support self-management. This moves towards a partnership relationship, where the use of professional expertise supports recovery. Peer workers can assist clinicians to better understand ways in which to build more effective partnerships with consumers and carers.

General Practices play a pivotal role in integrating a consumer's care to achieve a holistic approach. PHNs can work with General Practices and other clinical and community services

within the stepped care approach to support that integration.

Consumer and Carer Health Literacy and Empowerment

For consumers to control, lead and participate directly in the decisions that affect their lives and to effectively self-manage their mental illness, they require information and support to make health care choices and to interact with a variety of services to obtain the clinical and psychosocial support they need. Families and carers require similar information. This means having easily accessible information about mental health and wellbeing, mental illness, and illness management that is available in a range of formats, including culturally appropriate.¹¹

Peer support is important to the delivery of person-centred care. Peer support, for both consumers and their families and carers, can provide essential information, fellowship, role models, mentors and advocates.¹² Peer workers can focus on the personal strengths and resources of each individual consumer. The peer workforce can also provide a flexible, responsive framework that values the lived experience of consumers and carers.¹³

The Commission recommended the development and promotion of the mental health peer workforce as part of its review, *Contributing Lives, Thriving Communities*, and has developed guidelines for peer workers within PHNs. Additionally, in accordance with an action item detailed in the Fifth Plan, The Commission will be developing a 'Peer Workforce Development Framework' for the broader mental health system by 2020.¹⁴

The Community Services and Health Industry Skills Council's qualification 'Certificate IV in Mental Health Peer Work CHC43515' provides a specific career pathway to up-skill the peer workforce.¹⁵

PHNs can engage with peer workers in a range of ways, including as a central part of consultation processes, and may choose to directly employ peer workers to advise on the design, development, procurement and evaluation of PHN commissioned programs and services.

There is also a central role for consumer advocacy in the mental health system, as well as the broader health system. This advocacy must be supported and resourced.

System Changes

In addition to changing the way clinicians function and empowering consumers and carers to make decisions, systems based changes are required to support person-centred care. This involves not just PHNs but General Practice, service providers and government at the federal, state and territory level.

These systems changes include:

- amendments to reporting and contract arrangements
- innovative approaches to achieve better coordination of care
- enhanced information exchange
- development of clear referral pathways

- workforce development.

Stratifying regional PHN populations into different needs groups (well, at-risk, mild, moderate, severe) identifies the necessary interventions required to drive programme and service level improvements. Coordination of programmes and service delivery is essential, particularly at transition points, in order to deliver seamless care and a smoother consumer journey across the stepped care approach.

PHNs and service providers have acknowledged the benefit of real time information flow. Promoting options for enhancing information exchange, including through digital options is imperative to:

- support a seamless journey for consumers, where they do not need to repeatedly provide their history as they enter and re-enter the system across the stepped care approach
- accelerate knowledge transfer between service providers and clinicians
- reduce the reporting burden for service providers
- increase analytical capabilities
- understand the outcomes of targeted investment in mental health programmes.

PHNs also need to develop links and partnerships with the range of health and mental health professionals in their region to develop models of care that address physical and mental health issues. The Commission encourages clinicians, multi-sector organisations, governments and professional bodies to work together to make the physical health of consumers living with a mental illness a priority.¹⁶

PHNs can embed peer worker requirements into contract specifications with service providers, and consider other alternative workforce arrangements in the delivery of commissioned programmes and services, including low intensity workers.

Current funding models for general practice and hospital-based care predominantly focus on the person's specific episode of care, not on their whole person care and continuing care. Achieving person-centred care requires consideration of the way care is viewed, planned, designed, delivered, arranged, contracted and funded to encompass the whole person and continuing care requirements.

Progress Indicators and Actions

Person Centred Care

Progress Indicator: PHNs commission programmes and services that incorporate person centred principles, and there is a shared understanding of person and family centred care translated into systems, practices and outcomes.			
Action		Leads	Horizon
Action 4.1	Achieve person centered stepped care programmes and services, including preventative services aimed at maintaining	PHNs	3 years

	health and well-being through to care co-ordination and navigation of services, and incorporate digital mental health options where appropriate.		
Action 4.2	Enhance community awareness and knowledge of the range of programmes and services available across the stepped care approach	PHNs	4 years
Action 4.3	Support improved information flow by promoting the use of MyHealthrecord and the eReferral system to consumers and service providers in their region	PHNs	4 years

Functioning of Clinicians

Progress Indicator: PHNs consider the broader needs of mental health consumers, recognising that a range of different interventions and supportive approaches may be required at different times for any consumer			
Actions		Lead	Horizon
Action 4.4	PHNs work collaboratively with General Practices and key mental health service providers in the public and private sectors to promote the routine physical health assessment of mental health consumers, and to clarify roles and responsibilities of health practitioners and providers in relation to the physical health care of mental health consumers.	PHNs, state and territory governments, GP representative bodies, service providers	3 years
Action 4.5	Support General Practices to contribute to mental health system reform through their role as primary care gateways	PHNs	3 years
Action 4.6	PHNs enact their support for the <i>'Equally Well Consensus Statement'</i>	PHNs	2 years

Consumer and Carer Health Literacy and Empowerment

Progress Indicator: PHNs have a structured approach to engaging consumers, carers, and communities, and the services that are available in each PHN region are integrated and accessible			
Actions		Lead	Horizon
Action 4.7	PHNs and service providers leverage technology to engage and involve consumers and carers in the planning and co-design of reforms	PHNs	2 years

Action 4.8	PHNs and service providers work collaboratively to build the peer workforce, including resourcing consumers providing peer support to undertake the 'Certificate IV in Mental Health Peer Work CHC43515'	PHNs Service Providers	3 years
Action 4.9	PHNs embed peer worker requirements into contract specifications with service providers, informed by the peer workforce guidelines for PHNs and the Peer Workforce Development Framework developed by the Commission.	PHNs Service providers	3 years
Action 4.10	Reporting processes include consumer and carer rated measures of care, such as: Consumer and carer engagement Consumer and carer experience of care, including choice and control in the services made available	PHNs Commonwealth DoH	5 years

System Changes

Progress Indicator:			
Models of care support a regional stepped care approach, with evidence of increased collaboration to achieve service integration. This is demonstrated by active and practical coordination of services across all stakeholders including PHNs, private and public service providers and Non-Government Organisations (NGOs)			
Actions		Lead	Horizon
Action 4.11	Develop mechanisms to enable innovative models of care and learnings from PHN trial sites to be shared widely to promote national scaling up and/or joint commissioning with other PHNs	PHNs Commonwealth DoH	4 years
Action 4.12	Support and participate in communities of practice and collaborative forums (regional, state-based or national) as appropriate, to enhance regional stepped care readiness and build capacity to support person centred care	PHNs State/Territory DoH	4 years
Action 4.13	Notify primary care of mental health inpatient admissions and discharges as a part of real-time information flow.	LHNs State/Territory DoH	5 years
Action 4.14	Increase funding for research in mental health and suicide prevention in collaboration with relevant research funding agencies	Commonwealth DoH State/Territory DoH Universities	4 years

5. Safe and Quality Care

The Aspiration

Mental health and suicide prevention services that are safe and high quality deliver a positive experience of care and enhanced quality of life for consumers and their carers and families, particularly when there is an appropriate focus on recovery, not just on symptom management.

Optimising the safety and quality of mental health services commissioned by PHNs requires a focus on more than just the inputs and outputs of commissioned service providers. Robust clinical governance, appropriate standards of care, measurement of meaningful and contemporary outcome measures and a culturally competent workforce are all required to deliver safe and high quality care. Appropriate resourcing is also required, including investment in systems for data collection.

While PHNs have a role to build a robust primary mental health care system, they are not direct service providers and do not directly undertake the clinical governance or manage the workforce of the individual services and programmes they commission. They must clearly articulate the desired outcomes at the time of establishing a contract and review whether services are achieving the required outcomes, as part of the continuous cycle of commissioning.

All stakeholders in the primary care sector need to engage with PHNs to collectively build a system that provides person centred, safe and high quality mental health programmes and services. PHNs need to build effective clinical relationships among the wider mental health service system to support enhanced service innovation, performance improvement and service integration.

There is also a role for professional bodies and peaks to support safety and quality in primary mental health care services commissioned through PHNs; this would require a nationally coordinated approach for all PHNs to be conducted efficiently.

Clinical Governance

Safe and high quality care needs to be underpinned by robust clinical governance that enables appropriate standards of care to be maintained and clinical risk to be minimised. PHNs are not direct service providers to mental health consumers. However, as commissioners of mental health programmes and services, they need to actively oversee clinical governance for the programmes they commission.

Clinical governance needs to identify and monitor clinical risk, including tracking and trending of incidents and adverse events, complaints and compliments. A range of quality assurance measures, including clinical audits, credentialing and consumer feedback surveys, to monitor the standard of care need to be utilised. These outputs also inform quality improvement processes which are another essential component of clinical governance.

Service providers need to utilise data, incident patterns and trends, complaints and feedback to enable the monitoring of the safety and quality of care. The analysis of these data and trends is enhanced by structured and planned opportunities for stakeholders, including consumers, carers and families, and clinicians to contribute to the interpretation, validation and prioritisation of the findings.

PHNs need to have confidence that clinical risk is being appropriately managed and mitigated by service providers and that appropriate standards of care are maintained. This requires PHNs to establish effective structures and processes to ensure that the services they commission have appropriate clinical governance processes in place.

PHNs must incorporate appropriate clinical governance requirements into individual service provider contracts, tailored to the size and role of the programme; and must clearly articulate the actions to be undertaken when a service does not meet the required standards and quality. Reporting requirements should not over-burden service providers and detract from the core business of delivering safe, high quality care.

PHNs need to actively monitor the clinical governance of the services they commission and respond appropriately as required. By drawing upon their clinical experience, evidence based models of care and leading practice, Clinical Reference Groups can provide leadership and expertise to guide PHNs in mental health commissioning processes, including in the oversight of clinical governance processes and the management of clinical risk.

Appropriate Standards

In commissioning mental health programmes and services, PHNs must adhere to relevant national and state/territory legislation, and align with the *National Standards for Mental Health Services (NSMHS)*,¹⁷ the *National Safety and Quality Health Service Standards*,¹⁸ (NSQHSS) and the *National Framework for Recovery-Orientated Mental Health Services (NFROMHS)*.¹⁹

The NSMHS guide mental health services in the development and implementation of appropriate practices and continuous quality improvement. The Standards describe the expected level of care that is required to be delivered and PHN commissioned services are expected to reference and adhere to these standards.

The NSQHSS were developed by the Australian Commission of Safety and Quality in Health Care ('ACSQHC') and provide a quality assurance mechanism to enable minimum standards of safety to be met. Additionally, the standards facilitate a continuous quality improvement process. These standards provide a valuable reference point for good practice.

The NFROMHS highlights principles, practices and service delivery expectations for consistent high quality recovery orientated care. It reinforces the need to design and implement models of care that are holistic and support the physical, spiritual and community based needs of mental health consumers. It also describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery orientated principles.

Cultural Appropriateness

PHNs need to actively consider cultural and social appropriateness in all mental health commissioning arrangements. The role of PHNs includes supporting commissioned service providers to develop and maintain culturally and socially appropriate programmes and services that are safe and of high quality. Community leaders and peer workers, may also be utilised where appropriate, to enhance the delivery of culturally competent services.

The importance of Aboriginal and Torres Strait Islander views of social and emotional wellbeing, mental health and healing should be recognised and considered by PHNs when commissioning services for Aboriginal and Torres Strait Islander people. The *2015 Gayaa Dhuwi (Proud Spirit) Declaration*²⁰ comprises five themes on the importance of Aboriginal and Torres Strait Islander leadership to achieve the highest attainable standard of mental health and suicide prevention outcomes for these populations. It also references the nine principles of Aboriginal and Torres Strait Islander social and emotional wellbeing, and is a useful guide for PHNs when commissioning services for Aboriginal and Torres Strait Islander people.

The *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*²¹ has been developed to help service providers and individual workers to evaluate their cultural responsiveness and enhance their delivery of services for CALD communities. Utilisation of the framework by PHNs when commissioning services will not only assist the services to fulfil their existing safety, quality and accreditation requirements, but also support an ongoing process of assessment and development.

Training and Education

As commissioners of services, PHNs need to focus on the capacity and capability of service providers in their region. While not directly responsible for workforce development, PHNs are well placed to work collaboratively with service providers to identify opportunities for service improvement, benchmarking, knowledge transfer, and structured and informal capability development. Requiring commissioned services to adhere to minimum training and education standards for all mental health workers is a key strategy towards building capacity and capability, and may be further strengthened by incorporating requirements for credentialing into contracts where appropriate. Funding supervision and practice development when commissioning services is another option to both develop the workforce and enhance the safety and quality of services

Progress Indicators and Actions

Clinical Governance

Progress Indicator: A National Framework for Clinical Governance developed and implemented to guide PHNs			
Actions		Leads	Horizon
Action 5.1	Develop and implement a National	Commonwealth	4 years

	Framework for Clinical Governance to support consistency in the approach by PHNs to safety, quality and continuous improvement	DoH	
Action 5.2	Establish appropriate structures and processes within the PHN to enable appropriate Board oversight of clinical governance and monitoring clinical outcomes of the services commissioned within their region	PHNs	3 years
Action 5.3	Develop and utilise contracts that clearly stipulate the specific clinical governance reporting required by service providers and clinicians, and articulate potential actions when a service does not meet the required standards and quality	PHNs	3 years
Action 5.4	Routinely engage with clinicians through a formal structured mechanism e.g. a Clinical Reference Group, to provide leadership and expertise in the oversight of clinical governance processes and the management of clinical risk.	PHNs	2 years

Appropriate Standards

Progress Indicator: PHNs adhere to relevant national and state/territory legislation, and align with the National Standards for Mental Health, the National Safety and Quality Health Service Standards, and the National Framework for Recovery- Orientated Mental Health Services			
Actions		Lead	Horizon
Action 5.5	Commission mental health programmes and services that comply with relevant national and state/territory legislation	PHNs	1 year
Action 5.6	Commission mental health programmes and services that align with the National Standards for Mental Health Services, National Safety and Quality Health Service Standards, and the National Framework for Recovery Orientated Mental Health Services.	PHNs	3 years
Action 5.7	Support service providers to utilise the ACSQHC 'Accreditation Workbook' to self-assess against the requirements of the NSQHS Standards and the National Standards for Mental Health Services	PHNs	3 years

Cultural Appropriateness

Progress Indicator: PHNs actively consider cultural and social appropriateness in all commissioning			
Actions		Lead	Horizon
Action 5.8	Incorporate cultural and social appropriateness principles in all mental health commissioning arrangements	PHNs Service Providers	3 years
Action 5.9	Utilise community leaders, cultural advisors and peer workforce to develop and inform culturally competent services	PHNs Service Providers	2 years
Action 5.10	Actively support the 'Gayaa Dhuwi (Proud Spirit) Declaration' and incorporate its principles in mental health commissioning approaches	PHNs	1 year
Action 5.11	Promote the 'Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery' to all regional service providers and encourage them to evaluate their cultural responsiveness, including undertaking the Organisational Cultural Responsiveness Assessment that is within the Framework	PHNs	3 years

Training and Education

Progress Indicator: PHNs are required to have a focus on the capacity and capability of service providers and clinicians in their region			
Actions		Lead	Horizon
Action 5.12	Work with commissioned service providers to develop an understanding of the different capacity and capability requirements for the mental health workforce in the local region	PHNs	2 years
Action 5.13	Require commissioned services to be delivered by an appropriately skilled and capable workforce by specifying in contracts the minimum training and education standards required for all mental health workers	PHNs	3 years
Action 5.14	Identify opportunities for workforce development through education and training networks established in collaboration with service providers	PHNs Service Providers	4 years

6. Working with Aboriginal and Torres Strait Islander Services and Communities

Introduction

Improving Aboriginal and Torres Strait Islander health, mental health and suicide prevention are intersecting priorities for PHNs. The Fifth Plan requires that mental health services are culturally safe and able to deliver both a culturally and clinically competent service to Aboriginal and Torres Strait Islander consumers. This includes access to cultural healers and treatments as well as 'mainstream' clinical treatments.

Recognising that building trust, relationships and partnerships takes time, this chapter aims to provide guidance on how to achieve the best outcomes for Aboriginal and Torres Strait Islander people through the co-design of the above in collaborative partnerships.

Working in a Cultural Framework

Indigenous peoples locate physical and mental health within a broader concept called social and emotional wellbeing (SEWB). While the SEWB concept varies between groups, shared features include that it is:

- itself inseparable from culture
- holistic in conception
- comprises an inter-related set of *cultural determinants* that connect the health of individuals to the 'health' of their families (including culturally determined concepts of 'extended' family), kin cultures and communities, and their connections to these things, and to the spiritual world and ancestors
- affirms a stronger association between collective and individual wellbeing than that generally acknowledged in western societies.²²

Cultural rights are particularly relevant when two cultures co-exist. Cultural rights in this context provide agreed 'rules for inter-cultural engagement'. Article 24 of the United Nations *Declaration on the Rights of Indigenous Peoples* guides cultural rights relation to health. Of particular relevance, it states that:

*Indigenous peoples have the right to their traditional medicines and to maintain their health practices...*²³

Cultural healing practices and healers, including their contemporary forms, are an important part of the SEWB concept. Such may involve healing in different areas of life, and not just to the physical body or mind in isolation, in order to restore the wellbeing of the whole Aboriginal and Torres Strait Islander person. Strengthening SEWB is also an important concept when working with Aboriginal and Torres Strait Islander communities to build protective factors against, and otherwise prevent, mental health difficulties and suicide and among young Aboriginal and Torres Strait Islander people in particular.

Working with Experiential Difference

Understanding the historical and present-day impact of colonisation, including recent decades of Aboriginal and Torres Strait Islander communities and ACCHSs' experience of interacting with Australian governments and their agencies (not all of which has been positive), is important in maximising the benefits of working in partnership.

Indigenous history since colonisation has been a story of resilience and survival in the face of a colonisation process that has seen intergenerational trauma²⁴ and intergenerational poverty²⁵ impact on individuals, families and communities.

Many of the challenges to Aboriginal and Torres Strait Islander individual's mental health and SEWB have their ultimate origin in the historical and present-day collective experience of Aboriginal and Torres Strait Islander people. This includes trauma (as discussed above), higher exposure to life stressors and psychological distress and alcohol and other drug use. PHNs need to demonstrate both an understanding of the social determinants of mental health problems and suicide and a willingness to respond holistically and flexibly to the needs of Aboriginal and Torres Strait Islander communities.

Empowerment and self-determination

Empowerment is a necessary and non-negotiable characteristic of any response to Aboriginal and Torres Strait Islander community challenges, including to mental health difficulties and suicide. In terms of good practice, empowerment is likely to contribute to better mental health outcomes and suicide.

The *Declaration on the Rights of Indigenous Peoples* states that Indigenous peoples have the right to self-determination²⁶ and requires not only that Indigenous communities be 'actively involved' and 'participate' in decision making that affects them, but that before measures (including integrated approaches to suicide prevention) are adopted, a community must provide free, prior and informed consent to them. Guidance to this is provided in the forthcoming Black Dog Institute and Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention's *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities - A Guide for Primary Health Networks*.²⁷

Empowerment based approaches are not 'forced' onto a community; instead, they occur as communities create their own momentum, gain their own skills, advocate for their own changes and set their own timeframes, compatible with their own cultural protocols. As such, empowerment-based approaches informed by a commitment to community self-determination and culture are also likely to be more effective.

A focus on empowerment should be considered as contributing to risk management by helping PHNs avoid common pitfalls that have the potential to result in harm, such as assuming that what works in one Aboriginal and Torres Strait Islander community will work in another, or imposing approaches designed for non-Indigenous community settings.

Working in partnership with ACCHSs

Building CEO to CEO relationships with ACCHSs and community organisations is a good and respectful basis for PHNs seeking to establish partnership relationships with communities. In particular, an ACCHS is likely to be both a leadership role within a community, and/or be able to connect a PHN to a community's governing body.

ACCHS are also ideally placed for PHNs to partner with to support the co-design and co-implementation of integrated approaches to improving mental health and suicide prevention.

ACCHSs should also be positioned as preferred providers, and PHN funds for mental health and suicide prevention for Aboriginal and Torres Strait Islander people should be allocated to ACCHSs unless it can be clearly demonstrated that alternative arrangements can produce better results in terms of access to services and service outcomes. This is in line with the position set out by Aboriginal and Torres Strait Islander leaders in the *Redfern Statement of 2016*.²⁸

Market-based solutions such as competitive tendering which aim to maximise the return on investment of public funds only work in a functioning market. In contrast, in many Aboriginal and Torres Strait Islander communities, there is evidence of health services 'market failure'. ACCHSs are, in part, a response to this market failure in Aboriginal and Torres Strait Islander communities and provide health services that the market alone would not sustain. But even in Aboriginal and Torres Strait Islander communities where competitive tendering processes are possible, ACCHSs should be preferred as they are most likely to maximise the return on investment of public funds.

As ACCHSs are based in Aboriginal and Torres Strait Islander communities, they have community and cultural connections that are essential for promoting access to services. They also provide a culturally safe service environment and a culturally competent service experience. The available evidence indicates ACCHSs outperform mainstream services in recognising and dealing with chronic disease.²⁹ Partnering with ACCHSs which are leadership bodies in Aboriginal and Torres Strait Islander communities also supports community empowerment, self-governance and self-determination, and provides employment to community members to support community capacity building and the economy of their communities.

Embedding Cultural Capability in Mainstream Services

While ACCHS are the preferred providers of mental health and related services to Aboriginal and Torres Strait Islander communities, the Fifth Plan aims to '*embed cultural capability into all aspects of clinical care and implement the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 in mental health services*'.³⁰

The Cultural Respect Framework provides direction to ensure that PHN-Indigenous community co-designed and commissioned health, mental health and suicide prevention activities, programs and services are culturally safe and staff culturally competent. Its Vision includes that '*cultural differences and strengths are recognised and incorporated into the governance, management and delivery of health services*'.³¹

Listening and Working Together

Effective communication by PHNs with Aboriginal and Torres Strait Islander communities and ACCHSs will be facilitated by early and frequent engagement and by allowing time for the development of trusting and open relationships.

Strategies that might assist include:

- not having ‘formal’ meetings with Aboriginal and Torres Strait Islander communities (as might typically occur in business or government settings), but facilitating yarning circles and other ways of meeting that work with the way a community operates
- employing local Aboriginal and Torres Strait Islander staff to work across needs assessment, service assessment, and commissioning processes that involve Aboriginal and Torres Strait Islander communities
- supporting professional development of non-Indigenous staff and non-local Aboriginal and Torres Strait Islander staff to support PHN communication with ACCHSs and Aboriginal and Torres Strait Islander communities based on an understanding of culture and the needs of Aboriginal and Torres Strait Islander people for cultural supports
- understanding the high level of demand placed on ACCHSs and supporting them to participate in PHN fora among conflicting demands
- ensuring that approaches are based on two-way information sharing with the ACCHS and Aboriginal and Torres Strait Islander community
- training and/or Aboriginal and Torres Strait Islander mentoring of PHN CEOs and senior staff to support Indigenous-inclusive PHN governance
- reviewing PHN constitutions and Board-appointment processes and proactively appointing qualified Aboriginal and Torres Strait Islander people

Communicating effectively about the role of the PHN, including what they can and cannot do, what ‘commissioning’ means, and describing how the PHN intends to work with a community, and what it and the community could achieve together will assist in building trust.

Supporting the capacity of diverse Aboriginal and Torres Strait Islander mental health consumers to ensure their voice is heard, including in PHN fora and processes, is also important. Aboriginal and Torres Strait Islander consumers will be empowered by creating ‘safe’ fora for them to share their experiences of local and regional mental health and suicide prevention services, and their ideas about what services are missing or what or how services could be improved. To facilitate frank discussion, such spaces should be: culturally safe spaces; confidential spaces (in communities where ‘everyone knows everyone’); and spaces away from service providers. Where appropriate a translator should be engaged.

*Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities, A Guide for Primary Health Networks*³² discusses the need for whole-of-organisation approaches and commitment to working effectively in partnership with Aboriginal and Torres Strait Islander communities. Selected pointers to action include:

- Appoint local *Aboriginal and Torres Strait Islander* PHN board members who work with *Aboriginal and Torres Strait Islander* communities within a region to provide overarching

technical and adaptive leadership to the PHN. In many cases, Aboriginal Community Controlled Health Services' CEOs will be ideally placed for such a role.

- Ensure that PHN Community Advisory Councils (CACs) and Clinical Councils include Aboriginal and Torres Strait Islander members with expertise in the issues impacting Aboriginal and Torres Strait Islander communities within the PHN's region and that reach into remote communities if relevant.
- Ensure that PHN boards, CACs and Clinical Councils have protocols in place to ensure the cultural safety of their Aboriginal and Torres Strait Islander members and to otherwise support them in their roles. Examples might include: adding Aboriginal and Torres Strait Islander issues, including suicide prevention, as standing items on meeting agendas that are distinct from general population concerns; ensuring that a minimum of two Aboriginal and Torres Strait Islander people are present in any fora; and providing financial or transport support to attend meetings, particularly for people from remote areas.
- Ensure Aboriginal and Torres Strait Islander peoples are employed at all levels of a PHN's organisational structure including by direct recruitment and upskilling of existing Aboriginal and Torres Strait Islander staff. This can provide technical and adaptive leadership from within the organisation and help 'acculturate' the organisation and its non-Indigenous staff to work better with Aboriginal and Torres Strait Islander communities.
- Require all non-Indigenous staff to undergo cultural capacity-building training to understand the history, culture and other contexts within which local Aboriginal and Torres Strait Islander communities operate in the PHN region. Preferably, this training should be commissioned from local ACCHSs or Aboriginal and Torres Strait Islander providers.

Regional and local planning

The Fifth Plan³³ requires PHNs and LHNs to partner with a wide range of Aboriginal and Torres Strait Islander communities and organisations to develop an overarching regional 'integrated' mental health and suicide prevention plan. This may be best managed for both the PHN and the Aboriginal and Torres Strait Islander communities and organisations involved through a regional Aboriginal and Torres Strait Islander Health Council under cultural governance agreed by the communities and organisations involved.

Such a Council can provide a collective voice for otherwise diverse communities, and has the added advantage of providing a culturally safe working space for participants. By bringing communities together, it also helps address power imbalances between them as individual entities and PHNs/ LHNs. For PHNs, it can provide a collective point of contact for the development of the regional mental health and suicide prevention plans that incorporate systems approaches.

For both, an Aboriginal and Torres Strait Islander Health Council can help identify regional economies of scale and provide a platform for, and oversight of, the co-design and co-implementation of regional mental health and suicide prevention plans including integrated approaches to suicide prevention that are tailored to individual community needs.

Joint regional and local planning for Aboriginal and Torres Strait Islander people will require regional level data on the prevalence of mental illness in Aboriginal and Torres Strait Islander populations. The required data may be difficult to source and innovative data gathering techniques including involving Aboriginal and Torres Strait Islander communities in assessment processes may be required. There may also be potential for state and territory-level ACCHSs' peak bodies to assist with independent Aboriginal and Torres Strait Islander community mental health and related areas needs assessments.

Achieving agreement on an integrated service model for Aboriginal and Torres Strait Islander primary mental health and related services will provide the basis for assessing needs and commissioning services to meet gaps in Aboriginal and Torres Strait Islander communities (i.e. against that model). Identifying high risk periods (e.g. Christmas and the wet season in the Top End) will allow additional efforts to be invested at these times.

It is important for existing Aboriginal and Torres Strait Islander community mental health and suicide prevention capacities to be identified to support PHNs enhancing or 'value adding' to them. There is also potential to better harmonise State/ Territory and Commonwealth planning and to leverage their investment in mental health and suicide prevention services, along with ACCHSs.

Supporting individuals, families and community aspirations and proactively promoting good mental health and wellbeing, not just simply meeting mental health needs with mental health services, is essential in Aboriginal and Torres Strait Islander communities. This requires working with other agencies to ensure investment in preventative mental health initiatives, including addressing the social determinants of mental health problems, and improving social and emotional wellbeing and strengthening resilience against life stressors.

Commissioning cultural and clinical competent services

Priority Area 3 of the Fifth Plan³⁴ notes:

A lack of cultural competency and the attitudes of staff can have a significant impact on the cultural safety of Aboriginal and Torres Strait Islander consumers and co-workers, resulting in lower rates of access to services and fractured care. Cultural competence should be considered a core clinical competence capability, as it can determine the effectiveness of a service for Aboriginal and Torres Strait Islander peoples.

The Fifth Plan³⁵ also notes, '*Aboriginal and Torres Strait Islander leadership in mental health services is fundamental to building culturally capable models of care*'.

Negotiating and agreeing a flexible and responsive Aboriginal and Torres Strait Islander mental health and suicide prevention service delivery model should be an early focus of PHN and Aboriginal and Torres Strait Islander community and ACCHS collaborative relationships. While this does not mean the development of 'one size fits all' service model, key elements of the model should be culturally safe service environments and culturally competent service provision.

Mental health and alcohol and other drugs (AOD) funds may also benefit from being pooled in recognition that mental health and AOD problems are not usually separate problems in practice in Aboriginal and Torres Strait Islander communities. Where this occurs, reporting

requirements should also be rationalised to reduce the administrative burden on ACCHSs.

Further, as outlined above, a goal of commissioning processes should be to utilise ACCHSs as the preferred providers of mental health, suicide prevention and related area services to Aboriginal and Torres Strait Islander communities, wherever it is in the best interest of the Aboriginal and Torres Strait Islander community to do so. Frameworks and principles to support this should be embedded in the ways PHNs operate. While this approach does not guarantee funding to ACCHSs or exclude other providers per se, it acknowledges and values the existing role of ACCHSs as culturally safe and culturally competent holistic health care providers to Aboriginal and Torres Strait Islander communities.

In summary, commissioning processes are needed that:

- are understood by Aboriginal and Torres Strait Islander communities and ACCHSs
- bring resources to, and build capacity in, ACCHSs and Aboriginal and Torres Strait Islander communities
- support evidence based, integrated health, mental health and AOD services to meet the often-complex needs of Aboriginal and Torres Strait Islander people and Aboriginal and Torres Strait Islander communities
- are flexible enough to respond to crisis situations such as a potential suicide cluster
- utilise Indigenous-developed mental health and suicide prevention strategies and best practice materials to guide co-design processes

PHNs are advised to seek guidance on the implementation of their primary mental health stepped care service delivery model in Aboriginal and Torres Strait Islander community contexts to ensure culturally safe service environments and culturally competent service delivery at each 'step'.

System mapping in Aboriginal and Torres Strait Islander communities should identify each 'step' of the stepped care model and in addition, follow Aboriginal and Torres Strait Islander patients' transition across the stepped care model to understand weak points in engagement with and between mental health and suicide prevention services that could be addressed by the commissioning process.

Apps, social media and websites may be useful tools to help prevent mental health problems and suicide in Aboriginal and Torres Strait Islander communities, and to improve Aboriginal and Torres Strait Islander peoples' journeys across the steps of the primary mental health service delivery system.

Make use of existing guidance

There is a multitude of existing, evidence-based, guidance that has already been developed. Some of these documents include:

- *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023*³⁶. This emphasises the importance of community control of services, cultural strengths and cultural governance in its strategic directions.

- *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (2013)*³⁷ includes among its guiding principles that ‘*projects should be grounded in community, owned by the community, based on community needs and accountable to the community*’; and that suicide prevention activity should be ‘*based on Aboriginal and Torres Strait Islander definitions of health incorporating spirituality, culture and healing*’.
- Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project’s *Solutions That Work* report (2017).³⁸ This identifies community control, working in a cultural framework, involvement of Elders, cultural elements, culturally appropriate treatment and the cultural competence of staff as success factors in Aboriginal and Torres Strait Islander suicide prevention. Recommendation 1 is that all future Aboriginal and Torres Strait Islander suicide prevention activity should ‘*utilise and/or build upon*’ these success factors’. Recommendation 2 is that ‘*All Indigenous suicide prevention activity should include community-specific and community-led upstream programs focused on healing and strengthening social and emotional wellbeing, cultural renewal, and improving the social determinants of health that can otherwise contribute to suicidal behaviours, with an emphasis on trauma informed care.*’
- *Gayaa Dhuwi (Proud Spirit) Declaration* of the National Aboriginal and Torres Strait Islander Leadership in Mental Health (2016).³⁹ By Action 12.3 of the Fifth Plan,⁴⁰ Australian governments, PHNs and LHN’s are required to recognise and promote Aboriginal and Torres Strait Islander leadership including by supporting *Gayaa Dhuwi (Proud Spirit) Declaration* implementation.

Other sources of guidance include:

- Related to the above, NATSILMH have produced a *Co-designing Health in Culture Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide*⁴¹ (2018) to assist PHNs and LHNs with this task.
- NATSILMH have also produced a *Health in Culture Policy Concordance* (2018)⁴² developed to assist bodies navigate the Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention policy space, including the six Indigenous-specific strategic documents referenced in the 5th Plan, in a ‘one stop shop’ reference guide. The Concordance sets out clearly what is required of PHNs and LHNs in a contemporary policy context.
- Black Dog Institute produced a *PHN Guide to Evidence-Based Commissioning for a Systems Approach to Suicide Prevention*,⁴³ which included detailed advice on setting up multiagency groups to develop regional suicide prevention plans, the importance of funding local coordinator roles to facilitate collaboration, and guidance on engaging with Aboriginal health organisations including through local Aboriginal health councils.

The forthcoming *Implementing Integrated Suicide Prevention in Aboriginal and Torres Strait Islander Communities - A Guide for Primary Health Networks*⁴⁴ and the *Cultural Governance Framework for Suicide Prevention in Aboriginal and Torres Strait Islander Communities* (CGF)⁴⁵ (working title) currently being developed jointly by Centre for Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and the Black Dog Institute.

Glossary

For the purposes of the *Five Year Horizon for PHNs*, the key terms below have the following meanings.

Aboriginal Community Controlled Health Services (ACCHS): A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health service to the community that controls it, through a locally elected Board of Management.

Australian Commission on Safety and Quality in Health Care (ACSQHC): The agency that leads and coordinates national improvements in safety and quality in health care across Australia.

Carer: A person who cares for or otherwise supports a person living with mental illness. A carer has a close relationship with the person living with mental illness and may be a family member, friend, neighbour or member of a broader community.

Clinical governance: The framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Co-commissioning: Commissioning that involves two or more agencies working together, using each other's knowledge and expertise, to prioritise which services should be provided for which people, using public resources and the resources of communities.

Collaborative commissioning: Working collaboratively with partners across the system to commission services; leveraging the value of the knowledge, skills and expertise of people who use services, carers, front-line staff, providers and commissioners but not necessarily by pooling budgets or resources

Community supports: Non-clinical services in the community that assist people living with mental illness to live meaningful and contributing lives and support them in their recovery. These may include services that relate to daily living skills, self-care and self-management, physical health, social connectedness, housing, education and employment.

Community Managed Organisation (CMO): A not-for-profit, non-government organisation governed by a Board of Management. CMOs range from single-focus, locally based organisations to large national and international organisations working across a range of areas.

Community managed sector: The community managed sector is predominantly made up of not-for-profit organisations providing community-based support services that help keep people well in the community. They provide prevention, early intervention and rehabilitation programs and psychosocial services that support recovery from mental illness. Some also provide treatment-related and counselling services.

Co-morbidity: The presence of one or more diseases or disorders in a person, in addition to a primary disease or disorder.

Conjoint commissioning: Commissioning by two or more agencies where budgets and resources are pooled

Consumer: A person living with mental illness who uses, has used or may use a mental health service.

Contributing life: The National Mental Health Commission outlines that a contributing life is one where people living with mental illness can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe, stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering.

Digital mental health: The delivery of services targeting common mental health problems through phone, online and mobile interactive websites, apps, sensor based monitoring devices and computers. The term also extends to crisis lines and online crisis support services.

Discrimination (mental illness): Unfair treatment of a person or group of people on the basis of a particular characteristic. Discrimination happens when people act on stigmatising views about people living with mental illness.

Early intervention: The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness.

Gayaa Dhuwi (Proud Spirit) Declaration: A declaration on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

Governments: Commonwealth, state and territory governments.

Lived experience (mental illness): People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness. People with lived experience are sometimes referred to as consumers and carers.

Lived experience (suicide): People who think about suicide, people who have attempted suicide, people who care for someone with suicidal behaviour, people who are bereaved by suicide, and people who are impacted by suicide in some other way, such as a workplace incident.

Local Hospital Networks (LHNs): Entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being directly responsible for performance. Most, but not all, LHNs are responsible for managing public hospital services in a defined geographical area. At the discretion of states and territories, LHNs may also manage other health services such as community-based health services. LHNs may have different names in some jurisdictions. For example, they

are referred to as Local Health Districts in New South Wales, Health and Hospital Services in Queensland, Local Health Services in South Australia, and the Tasmanian Health Service in Tasmania.

Mental health: The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

Mental health service system: Comprises all services that have a primary function of providing treatment, care or support to people living with mental illness and/or their carers.

Mental illness: A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.

National Disability Insurance Scheme (NDIS): Provides eligible participants with permanent and significant disability with the reasonable and necessary supports they need to enjoy an ordinary life. The NDIS also connects people with disability and their carers, including people who are not NDIS participants and their carers, to supports in their community.

National Safety and Quality Health Service (NSQHS) Standards: Standards that aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.

National Standards for Mental Health Services (NSMHS): Standards that assist in the development and implementation of appropriate practices and guide continuous quality improvement across the broad range of mental health services.

Indicator: A quantitative measure that is used to assess the extent to which a given objective has been achieved.

Peer worker: Workers who have a lived experience of mental illness and who provide valuable contributions by sharing their experience of mental illness and recovery with others. Peer workers are employed across a range of service settings and perform a variety of roles, including providing individual support, delivering education programs, providing support for housing and employment, coaching and running groups and activities.

Person-centred Treatment: Care and support that places the person at the centre of their own care and considers the needs of the person's carers.

Prevention (mental illness): Action taken to prevent the development of mental illness, including action to promote mental health and wellbeing and action to reduce the risk factors for mental illness.

Prevention (suicide): Action taken to reduce the incidence of suicide.

Primary Health Networks (PHNs): Entities contracted by the Commonwealth to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of

poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

Primary care: Generally the first point of contact for people living with mental health problems or mental illness and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists and Aboriginal and Torres Strait Islander health workers.

Productivity: The efficiency with which inputs (such as labour) are converted into outputs (such as goods and services). Growth in productivity can lead to improvements in living standards.

Promotion (mental illness): Action taken to promote mental health and wellbeing.

Psychosocial disability: The disability experience of people with impairments and participation restrictions related to mental illness. These impairments and restrictions can include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Quality: The best possible health outcomes given the available circumstances and resources, consistent with patient centred care.

Recovery: The National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers outlines that there is no single description or definition of recovery, because recovery is different for everyone. It notes that central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination. Some characteristics of recovery commonly cited are that it is a unique and personal journey; a normal human process; an ongoing experience and not the same as an end point or cure; a journey rarely taken alone; and nonlinear, with it being frequently interspersed with both achievement and setbacks. It defines personal recovery as being able to create and live a meaningful and contributing life in a community of choice, with or without the presence of mental illness.

Regional level: The level between the macro level of governments and micro level of service delivery. The regional level is where practical, targeted and locally appropriate action can be taken and strong community collaborations and partnerships can be formed. A region is not necessarily confined to the boundaries of a specific Primary Health Network or Local Hospital Network.

Safety: Reducing the risk of unnecessary harm to an acceptable minimum level. An acceptable minimum level refers to the level of risk that is generally acceptable given the level of current knowledge, available resources and the context in which care is delivered weighted against the risk of having or not having treatment.

Secondary care: Care provided by medical specialists. Secondary care providers can include psychiatrists and psychologists.

Severe mental illness: Characterised by a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning. Severe mental illness is often described as comprising three subcategories:

- Severe and episodic mental illness—refers to people 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 people with a severe mental illness where symptoms and/or associated disability continue at moderate to 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 multi-agency needs—refers to people with severe and persistent illness whose symptoms are the most severe and who are the most disabled. The most intensive clinical care (assertive clinical treatment in the community often supplemented by hospitalisation), along with regular non-clinical support from multiple agencies, is required to assist the person in managing their day-to-day roles in life (for example, personal and housing support). This group is relatively small (approx. 0.4 per cent of adult population, or 60 000 people) and is the group targeted for Tier 3 packages under the NDIS.

Severe and complex mental illness: Refers to mental illness that is not directly aligned to any one of the above subcategories of severe mental illness. Rather, it is broader and may include episodic or chronic (persistent) conditions that are not confined to specific diagnostic categories. While incorporating severely disabled people (that is, people with persistent illness with complex multi-agency needs), it also includes people who have complexities that are not disability related—for example, people who have a severe mental illness comorbid with a chronic physical illness; people who may have no functional impairment arising from their mental illness but whose illness is adversely impacted on by complex social factors; people with multiple recurrent acute episodes that require frequent hospital care; people who present a high suicide risk; or people who have a need for coordinated assistance across a range of health and disability support agencies.

Social and emotional wellbeing: Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.

Social inclusion: The opportunity for people to participate in society through employment and access to services; connect with family, friends, personal interests and the local community; deal with personal crises; and have their voices heard.

Specialised mental health services: Include services provided by psychiatric hospitals, psychiatric units or wards in hospitals, community mental health care services and residential mental health services.

Stepped care: An evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower-intensity services as their needs change.

Stigma: A negative opinion or judgment that excludes, rejects, shames or devalues a person or group of people on the basis of a particular characteristic. Stigma may include self-stigma,

social stigma and structural stigma. Stigma against people living with mental illness involves perceptions or representations of them as violent, unpredictable, dangerous, prone to criminality, incompetent, undeserving or weak in character.

Suicidal behaviours: A range of behaviours that include thinking about suicide (ideation), planning a suicide, attempting suicide and taking one's own life.

Trauma informed care and practice: An organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for consumers, their families and carers, and service providers.

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