

Report of the PHN Advisory Panel on Mental Health

September 2018

Introduction

The PHN Advisory Panel on Mental Health (the Panel) was convened to provide advice to the Minister for Health about the progress of mental health reform being implemented through PHNs.

The Panel identified that this reform process is complex and noted that while all PHNs have commenced on the journey towards transforming mental health services in their region, further time and support will be required to ensure that the reform is able to fully deliver the promised results.

To assist all stakeholders in understanding the key domains in which change must take place to maximise the outcome of the reform, the Panel developed a strategic document, *Reform and System Transformation: A Five Year Horizon for PHNs*. This report should be read in conjunction with the *Five Year Horizon for PHNs* document.

Background

The National Mental Health Commission's *Contributing Lives, Thriving Communities: Review of Mental Health Programs and Services*, released in November 2014, detailed the urgent need for significant change across mental health services in Australia.¹ The review identified a system that is not appropriately integrated, with evidence of fragmentation and siloing of services and programmes. People experiencing mental health issues were unable to consistently access appropriate services or support, resulting in a negative impact on their wellbeing and level of participation in the community.

The Australian Government response to the Commission's Review committed to strengthening and extending the role of the newly established Primary Health Networks (PHNs) to provide a regionally driven approach to mental health services, through their local community knowledge and developing commissioning capability.² It foreshadowed the PHNs as commissioners and system integrators of mental health care, particularly through the adoption of a person centred, stepped care approach.

The Fifth National Mental Health and Suicide Prevention Plan, endorsed by the Council of Australian Governments (COAG) Health Council in August 2017, also supports this regional approach and commits all governments to work together to achieve integration in planning and service delivery at a regional level, particularly through collaboration between PHNs and Local Hospital Networks (LHNs).³ Importantly, it also mandates that people living with mental health issues and their carers must be central to the way in which services are planned, delivered and evaluated.

Other significant changes are also occurring, in particular, the scaling up to full roll out of the National Disability Insurance Scheme. The implementation of the NDIS has created significant disruption in the community mental health sector and this changing dynamic represents an important interface that PHNs must consider when planning and implementing mental health reform in their regions. Appropriate linkages to alcohol and other drugs (AOD) and other social services also need to be considered in planning and implementing mental health reforms.

¹ National Mental Health Commission, 2014: *Contributing Lives, Thriving Communities – The Review of Mental Health Programmes and Services*. Sydney

² Commonwealth Department of Health, 2015: *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*. Canberra

³ Commonwealth of Australia, 2017: *The Fifth National Mental Health and Suicide Prevention Plan*. Canberra

Primary Health Networks (PHNs)

The role of regional health organisations has evolved over many years, starting with Divisions of General Practice in the 1990s. From 2011, Divisions were replaced with Medicare Locals. On 1 July 2015, thirty-one PHNs were established, replacing the former Medicare Locals. Each PHN is governed by a skills-based Board.

PHNs are funded to commission services to meet the needs and priorities for their regions, whereas Medicare Locals were, in many cases, providing services. Establishing PHNs as commissioners represents a fundamental shift in the way healthcare services are planned and funded at the regional level.

Some PHNs operated formerly as Medicare Locals, and even as Divisions of General Practice; some within the same regions. Other PHNs were established as new organisations, and/or with different geographical boundaries. As such, the history of individual PHNs in their communities varies greatly.

There is good evidence that health systems with strong integrated primary health care at their core are both effective in improving patient outcomes and experiences, and efficient at delivering appropriate services where they are needed most.

In line with this, the key objectives for PHNs have been to increase the efficiency and effectiveness of clinical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time. PHNs work directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.

The initial mandate of PHNs is predominantly to focus on individuals within the mild to moderate spectrum of mental illness, with a limited role for those at the severe end of the illness spectrum. However, recent budget initiatives have seen PHNs given a role to commission and integrate broader, psychosocial supports, in addition to treatment services, and this will be targeted at those with significant psychosocial disability as a result of their mental illness.

In their first year of operation (2015-16), the focus for PHNs was establishing the organisation and planning for commissioning. Service continuity and funding was largely determined by previous arrangements. Commissioning of new services commenced from 2016-17. However, there has been variability in the timing and approach to commissioning across PHNs, reflecting both the timing of government direction and advice, and the different approaches that PHNs have taken in their regions to determining needs and establishing community stakeholder relationships. As well, it has been necessary to carefully plan commissioning to minimise the impact on consumers and the burden on service providers, particularly where funding has not grown substantially and in areas with limited workforce capacity.

Mental health is one of six key priorities for targeted work by PHNs with other agreed priorities being Aboriginal and Torres Strait Islander health, population health, health workforce, e-Health and aged care. The requirement to simultaneously manage a range of programme areas undergoing reform has added to the complexity of the task for PHNs.

PHNs manage approximately 10% of the Australian government's expenditure in mental health. Approximately 60% of PHN mental health funding is now attributed to the flexible funding pool. 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.

Three years on from their establishment, stakeholder input to this review suggests significant variability between PHNs with respect to their organisational capability and capacity to implement mental health reform. Some PHNs demonstrate significant progress and achievements as change agents and system integrators while others evidence less readiness for these roles, with a commensurate diminution in their progress. Contextual factors (e.g. the buy in of LHNs and levels of GP engagement) have also influenced variations in the rate of progress to date.

Support for PHNs

The Australian Government Department of Health currently plays a key role in supporting PHNs on their reform journey. In addition to their governance role in managing contracts with PHNs, the Department also have a role to support capacity building in PHNs. Some stakeholders have suggested that the Department's role in governance and contract oversight is not compatible with its role as a capacity builder for Primary Health Networks.

The Department has provided high level guidance and advice to PHNs on a broad range of issues including stepped care, co-design and best practice commissioning. Through regular PHN forums, they facilitate the sharing of information between PHNs, as well as between PHNs and a small number of national organisations and professional bodies as required. Clearly, these regular forums should include consumers, carers, national bodies, professional associations and providers from across the sector. They should also be used to promote best practice models of care derived from national and international evidence and to demonstrate how this evidence can be adapted and realised in a local regional context. Some national bodies (e.g. Black Dog Institute) are also directly funded to support PHNs towards achieving best practice. Disseminating PHN learnings from the evaluation of innovative models of stepped care, including from the PHN trial sites, can also be progressed through these forums. In this way, the broader uptake of successful innovative models can be facilitated.

To support their reform journey, PHNs have instituted an alliance within each jurisdiction and more recently, have also established a support position to serve as a central point of co-ordination for all PHNs. However, unlike the former Medicare Locals which had the Australian Medicare Local Association established to lead and support them, there is no overarching national PHN entity.

Stakeholders in mental health reform

Although a strong integrated primary health care system is integral to mental health reform, PHNs cannot achieve system transformation alone. There are a range of stakeholders that are responsible and accountable for driving mental health reform. These stakeholders include:

- Consumers, carers, families and communities
- Mental health service providers and practitioners
- National organisations with mandates for quality and evidence based reform
- General Practitioners (GPs)
- PHNs
- Research/Education organisations
- Sector peak bodies and multi-sectorial stakeholder entities
- Aboriginal Community Controlled Health Services (ACCHSs)
- State, Territory and Local Government
- Commonwealth Department of Health
- National Mental Health Commission
- Mental Health Australia

In endorsing the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), the COAG Health Council acknowledged that many stakeholders have important contributions to make towards achieving effective reform. It is essential that the same governments that agreed to the Fifth Plan now deliver on their commitment to ensuring that LHNs work collaboratively with PHNs, in regional planning, commissioning and in workforce development.

PHN Advisory Panel on Mental Health

Significant but ad hoc scrutiny has been applied to the roll out of mental health reform in PHNs, even at this relatively early stage of implementation, and a number of issues have been raised which are discussed below.

To better understand these issues and to receive advice on the progress of reform, the Minister for Health, the Honourable Greg Hunt MP, established a time-limited PHN Advisory Panel on Mental Health (the 'Panel') and invited recommendations from the Panel on steps that could be taken to support the progress of reform.

The membership and terms of reference for the PHN Advisory Panel on Mental Health are at [Attachments 1 and 2](#).

Methodology

The Panel held five face to face meetings between May 2017 and June 2018 which allowed for constructive discussion about the role of PHNs and the opportunities and challenges they encounter in implementing mental health reform. The Panel also conducted two forums to engage with a broad range of invited stakeholders relevant to mental health reform (see [Attachment 3](#) for a list of invitees) and to hear their views on the progress of change.

The Panel was assisted by work commissioned by the Department of Health and conducted by EY, including a literature search on national and international best practice in clinical commissioning and consultations involving key stakeholders, including PHNs, consumers, carers and community members.

Cross-sectional assessment of PHNs

The consultation conducted by EY for the PHN Advisory Panel gave an indication of some of the current strengths of PHNs, as well as some opportunities for PHNs to further develop.

Overall, the EY consultation reported that PHNs are at different levels of maturity as organisations (largely dependent on whether they transitioned directly from a previous Medicare Local and thus were built from an established governance and operational base). Stakeholders also reported that PHNs are at different levels of readiness in terms of their role as a commissioner and integrator of primary mental health services. In spite of their differing baselines, all PHNs have been endeavouring to deliver against very challenging deadlines, but there are still no objective criteria available to measure their relative performance reliably.

Key observations from the consultation conducted by EY include:

- Regional planning was progressively being strengthened and utilised by PHNs in the development of mental health and suicide prevention plans.
- Integration of regional data sources remains a barrier to accelerating a comprehensive view of population mental health needs.
- Some PHNs are progressing towards leading commissioning practices.

- PHNs recognised that internal and service provider capability needs to be enhanced to further drive market stimulation.
- PHNs acknowledge that it is essential to engage consumers, carers, families and the community in all phases of the mental health commissioning cycle. However, there was inconsistent evidence that this was being adopted systematically throughout the commissioning cycle nationally.
- As commissioners, PHNs are progressing towards the integration of programmes and services to support better mental health outcomes for consumers, carers, families and communities through a person centred approach.
- PHNs largely identified that aligning to the stepped care approach was a priority.
- The approach to clinical governance varied across PHNs, including differing views of the level of oversight required. PHNs recognised their role in minimising clinical variability and risk in the programmes and services they commission by enabling access to consistent, safe and high quality care, supported by continuous quality improvement practices.

Key findings - Issues and opportunities

A range of issues were raised with the PHN Advisory Panel, including many that present opportunities for enhancing the implementation of the current reforms. An overview of the issues and opportunities are set out below:

1. Variation between PHNs in programmes and services
 - Devolving the responsibility for commissioning to the regional level and requiring PHNs to tailor services to local needs and markets has (not surprisingly) resulted in different service models across the thirty-one PHNs. This has sparked concern about the tension between regional autonomy and national consistency, and has challenged all stakeholders to consider the appropriate balance between the two.
 - Core to these concerns has been considerations about the availability, interpretation and application of the evidence base by PHNs in their commissioning. Stakeholders differed as to who might make the decision that evidence has reached a threshold deserving national application in all thirty-one PHNs, and the implications this might have for local autonomy.
 - Where the evidence base is strong and there are nationally agreed models of care, it is expected that PHNs will demonstrate fidelity to the established models of care, unless there are convincing local circumstances that mitigate against this.
 - Where the evidence base is less well established, the need for innovative approaches and the opportunity to add to the evidence base is accepted and encouraged and should be funded accordingly.
 - Some stakeholders have also questioned whether the variability between services and across PHNs results in increased fragmentation of the service system. However, if a person centred perspective is adopted, it is readily apparent that the key factor determining whether services are fragmented is not the number and type of service offerings but the experience of the consumers and carers using the system, and whether their experience moving across services is co-ordinated, smooth and effective. The aim of PHN commissioning should always be to achieve a service offering for consumers and carers that is as integrated and seamless as possible.

2. Engaging, Listening and Acting

- The importance of genuine stakeholder engagement and co-design was emphasised, including with the regional community, consumers and carers, and clinicians and service providers.
- It was noted that different approaches are being taken by PHNs to engaging with stakeholders. However, there also appears to be considerable variation in the level of understanding and in the capability of some PHNs to achieve genuine engagement and participation of relevant stakeholders, and the uptake of 'co-design' as articulated in the Fifth Plan is not yet well established across all PHNs.
- Working in partnership with Aboriginal Community Controlled Health Services (ACCHS) was recognised as essential to achieving best outcomes for Aboriginal and Torres Strait Islander peoples, although many PHNs have still to develop a robust partnership with the ACCHSs in their region.
- It was noted that PHNs have neither the resources nor the power to mandate the participation of other stakeholders and hence must operate largely by influence, which requires strong trusting relationships that take time to develop.

3. Regional Planning

- There is wide-spread agreement about the need to plan services based on a thorough understanding of regional needs, and strong support for achieving a more person centred approach.
- While PHN regional variations should be recognised in the planning approach, adherence to a consistent national framework, as far as possible, is also recognised as essential.
- There remains a challenge for PHNs to access relevant regional and local level data, as in some cases, the data does not exist at regional or local level, or is not shared by state and territory authorities (in spite of Fifth Plan commitments).
- While there was considerable support for the broad concept of stepped care, there is no agreement about what constitutes a stepped care approach to service delivery and commissioning, or how to best achieve it.
- Many stakeholders expressed concern that there is little evidence of the 'missing middle' in the stepped care approach being addressed through PHN commissioning, although it was acknowledged that the funding that would be required to address this gap has not been made available to PHNs.
- It was recognised that there can be challenges in achieving integration across the 'steps' in the stepped care model, particularly when different providers are commissioned, sometimes by differing funders, to deliver different steps within the model.
- The need for a stronger focus on integrating mental health and alcohol and drug services and suicide prevention services, and social and emotional wellbeing services with mental health was a consistent theme, albeit that the separate funding and reporting structures inhibit PHNs in achieving the desired level of integration.
- The governance model of the PHN should deliver integration, both across the 'steps' in the model as well as across disciplines and other domains.
- There was strong consensus on the importance of addressing the social determinants of health and supporting the psychosocial disability needs of mental health consumers, but recognition that, to date, PHNs have had no ability to commission services in this area (apart from those PHNs which currently retain funding for services such as Partners in Recovery

that are in the process of transitioning to the NDIS). The 2017 budget initiatives will begin to provide some capacity for PHNs to address psychosocial needs, but this funding will clearly be inadequate to meet unmet community need.

4. Commissioning and Decommissioning

- Of all of the work undertaken by PHNs, commissioning is perhaps the most challenging and the least well understood.
- The importance of securing a shared understanding among stakeholders of PHN commissioning processes was acknowledged, including clearly articulating what are considered to be appropriate methodologies for PHNs when commissioning.
- In particular, it was noted that there is an important opportunity to move away from market forces alone driving commissioning, and towards a 'high trust' commissioning environment as detailed in the study *Commissioning and Contracting for Better Mental Health Outcomes* (Attachment 4).
- Irrespective of commissioning methodology, there is a need to ensure that appropriately transparent, accountable and robust commissioning processes are delivered, and that the rationale for all commissioning decisions is clear to interested parties.
- There was an emphasis on the need for ongoing evaluation and monitoring of commissioned services in each region, co designed with consumers and carers, to inform future commissioning decisions.
- It is also proposed that some services and activities would be more effectively managed through national commissioning, rather than regional commissioning, e.g. online and telehealth services; and services for survivors of torture and trauma
- Decommissioning of services by any PHN requires a robust and comprehensive transition plan that effectively engages with consumers, carers and the community as well as clinicians and service providers. A key focus must be on sustaining the continuity of mental health care for consumers while planning appropriate handover, and on ensuring appropriate timeframes are provided for any change to be effected.
- Any decision to decommission a service must also be consistent with the principles of transparency and accountability, and with the interim funding required to support seamless transitions.

5. Governance and reporting

- It was widely agreed that PHNs are expected to demonstrate appropriate governance with respect to the services and programmes they commission and decommission, and the outcomes being achieved.
- However, there was a level of disagreement amongst Panel members and stakeholders about whether PHNs themselves require a greater level of oversight than is currently in place through their Boards and via their contracting arrangements with the Department of Health, and what mechanisms might provide such oversight.
- Some felt that the current measures were reasonable and sufficient and in line with the policy intent of devolved decision making and governance.
- Others held the view, including the Co-Chairs of the Panel that the current measures, including reporting to the Department of Health, need to be enhanced by greater transparency and accountability and by greater opportunities for expertise from across the sector to influence the way in which the Department manage PHNs on behalf of the Government.

- A view was expressed that the design of the system of governance for the PHNs was inadequate given the significant public funds entrusted to them, and that the public interest would be better served if there was greater central oversight and/or control over their decisions, either by the Department of Health or another overarching entity.
- All Panel members agreed that enhanced visibility of the performance of PHNs would be well received, as currently there is limited information publicly available to those outside the PHNs and the Department, despite significant amounts of data being collected by PHNs. It was also noted that the same commentary could be made in relation to enhancing the visibility of the performance of other entities that are funded by Government(s) to provide mental health services, as often limited meaningful information is publically available.
- While there is a Minimum Data Set for PHNs, its ability to facilitate meaningful comparisons on the outcomes of commissioned services is not yet apparent. PHNs may collect other non-standardised data on the services they commission but this makes it difficult for stakeholders to form informed views about the outcomes achieved by the PHNs.
- It was identified that there is substantial opportunity to review and streamline PHN reporting requirements, with PHNs currently required to manage multiple funding sources, each with separate reporting requirements. This adds a level of unhelpful complexity to the seamless service landscape they are endeavouring to deliver.
- It was acknowledged that the level of scrutiny and commentary on PHN performance appears to exceed the scrutiny of other parts of the mental health sector involved in the reform journey. It was debated as to whether this was reasonable, given the context of the current reform and the concerns held by some about the adequacy of the governance system for PHNs, or whether this level of scrutiny was patently excessive, given that the investment in PHN mental health funding represents only 10% of all Department of Health mental health related expenditure. Those who held the latter view noted that an appropriate level of accountability should be required of all stakeholders who receive public funding.

6. Funding

- It was universally agreed that uncertainty associated with the funding contracts for the PHNs (e.g. relatively short duration of contracts and ultra-short notice of renewal in many instances) has impacted on their ability to undertake best practice commissioning with service provider organisations and added to the destabilisation of the community mental health sector that is already experiencing significant disruption on the back of the implementation of the NDIS.
- The short term nature of PHN funding has led to even shorter contract terms for providers, resulting in a situation that is even more uncertain than before PHNs were established. This is a devastating and unintended consequence of the reforms.
- While recognising that achieving efficiency was important, there was agreement that the level of funding for administration (overheads) for the PHNs, set initially at approximately 6% of their budget and recently announced to increase to 8%, made it challenging for PHNs to undertake capacity building and market stimulation activities where required. This was particularly notable because of the changing service landscape associated with the NDIS implementation, historic underfunding, market thinness and workforce challenges in some regions, particularly in rural and remote areas.
- Noting that the policy intention in setting up PHNs was to demonstrate efficient administrative processes, the current level of administrative funding, at approximately half

the benchmark figure for other funded entities across the public/private sector, is inadequate to support best practice and must be eased if better outcomes are to be achieved in capacity building and workforce development.

- It was also agreed that PHNs should receive sufficient, additional funding to allow them to establish 'co-design' with consumers and carers and to consult and engage more completely with stakeholders, including national organisations where appropriate. This should not be considered as part of the administration funding allocation but rather it should be separately funded.

7. Safety and Quality

- There is an opportunity to strengthen understanding of the respective roles and responsibilities of PHNs and commissioned services in relation to clinical governance.
- Supporting PHNs to enable them to learn from each other in terms of their commissioning experiences, models of care, workforce development, etc, and to efficiently engage with the rest of the mental health sector was seen as essential. While there was discussion about the most effective way to achieve this, there was agreement this will require additional investment.
- A single point of strategic coordination to support consistent communication with PHNs was seen by most as highly desirable. While some stakeholders saw this being fulfilled by establishing an overarching national entity, it was agreed that this was not the only way to achieve this function. It was noted that the Review of Medicare Locals by Prof. John Horvath cautioned against replicating the AMLA model. It was also noted that PHNs have recently created and recruited to a position to fulfil a central coordination function.
- Ensuring that there is a systematic approach by the Department of Health to assisting PHNs with lower levels of capability to continue to improve their performance was seen as highly desirable, although some Panel members expressed significant reservations about the capability of the Department to fulfil this role.
- Workforce development was seen as a central issue requiring further attention. Regional workforce planning and development is imperative, but it cannot progress in the absence of a national mental health workforce strategy.

8. Important Themes

- The Panel noted that the reforms implemented through PHNs have impacted a range of professional groups in the primary mental health domain, e.g. mental health nurses through the changes to the administration of the Mental Health Nurse Incentive Program, and psychologists through the changes to the ATAPS Program. In the face of such changes, there was agreement that it is important that the rationale for the changes be widely understood, and that there was adequate consideration of their potential for adverse impact on mental health consumers, as well as on the employment terms and conditions of individual professionals.
- All this suggests that PHNs have not been funded or directed adequately or given adequate lead times to manage the kind of change that they are being asked to implement.
- All agreed that there has been a high level of expectation placed on the PHNs to deliver results in mental health reform within extremely tight timelines. It was also agreed that PHN performance is negatively impacted by funding shortfalls, short timeframes and inadequate support.

- The Department of Health has also been similarly impacted by tight implementation timelines, with the development of support resources for PHNs lagging or progressing along with the reforms, rather than in advance of them, in many instances.
- Understanding was also sought on what will happen when the trials being conducted in the PHN trial sites conclude, both in terms of the funding and also the continuation of the services that have been commissioned as part of the trials.
- It was not always evident whether (and how) other stakeholders in the mental health sector have considered their own role in contributing to the overall reform of the mental health service delivery system, or how reform in their organisation or professional group could complement and support the work of the PHNs.

A Five Year Horizon for Mental Health Reform and System Transformation

In light of the differing opinions voiced by stakeholders about the progress of mental health reform in PHNs and the absence of clear milestones for PHNs along the reform journey, the Panel agreed that it was important to clearly articulate the key functions expected of PHNs in their role as regional commissioners and system integrators for mental health services, and in particular, to provide an indicative timeframe for the progress of reform.

The Panel developed the *'Mental Health Reform and System Transformation – a Five Year Horizon'* ([Attachment 5](#)). This is a strategic document that takes into account the issues that have been raised by consumers and carers, along with PHNs and other stakeholders. It articulates the key areas of focus for PHNs in six domains that, if implemented, will focus and accelerate the reform process. It includes specific actions to guide PHNs' transformation journey, along with progress indicators. As such, it can be used as a basis to assess their progress towards reform goals and PHNs should be encouraged to self-assess against this framework on a regular basis.

Critical success factors

In embarking on any reform, it is important to understand what factors are critical to success and what will enable change to occur.

Four critical success factors have been identified as being fundamental for PHNs to lead the successful achievement of mental health reform and system transformation within the current complex mental health policy and operating environment. They include:

- **Change readiness**
PHNs must ensure a coordinated environment where key stakeholders can engage effectively in the changes linked to progressing implementation milestones, sustain new ways of working and employ new thinking about the delivery of better mental health outcomes for consumers.

Articulating the burning platform for change, developing a clear regional vision in collaboration with key stakeholders, and building stakeholder, service provider and practitioner capacity in line with the expected capability required to effectively deliver on the five year milestones is an essential component to progressing regional readiness.

- **Change adoption and sustainability**
The success of new programmes and services for consumers and the community will rely heavily on the readiness of individuals working within the sector to operate in a more integrated way, placing the consumer at the centre of mental health care.

Change management does not occur without resourcing and support. PHNs should be asked to account for their investment in activities that promote and support change.

- **Governance, monitoring and evaluation**
PHNs need to adopt a planned approach to transformation implementation supported by structured governance arrangements and a comprehensive programme monitoring framework. Regular evaluation of transformation activities will serve to reinforce responsibilities and accountabilities across all relevant regional stakeholders and enable timely and responsive management of agreed activities. Consumers, carers, families and communities should be included in the conception, design, commissioning, implementation and evaluation of programmes and services.
- **PHN maturity development in line with the Fifth National Mental Health and Suicide Prevention Plan**
The Fifth Plan commits the mental health system to a nationally agreed set of priority areas that are integrated to build stronger, more transparent, accountable, efficient and effective services for consumers. It provides the imprimatur for PHNs to assume a growing leadership role in local mental health reform and supports the transformational activities outlined in the Five Year Horizon. However, it remains imperative that the commitments made in the Fifth Plan are honoured and that change occurs across the broader mental health system in addition to reform occurring within PHNs.

Key Enablers

A range of enablers have been identified that will support the achievement of the Five Year Horizon and progress maturity towards the outcomes described in the Fifth National Mental Health and Suicide Prevention Plan.

Common key enablers include:

- **Consumer, Carer, Family and Community Engagement**
 - Genuine engagement and co-design with community members and those who are experts through lived experience can ensure services are relevant and person-centred.
- **Partnerships**
 - Effective partnerships, including with clinicians, service providers, LHNs and national organisations will facilitate collaborative commissioning and long-term sustainability.
- **Leading commissioning practices**
 - Commissioning practices characterised by ‘high trust contracting’ and consensus amongst co-design partners and stakeholders, rather than standards tenders and procurement processes, will ensure that services are fit for purpose.
- **Data**
 - Data and evidence are central to advancing and improving regional mental health planning and mental health reform.
- **Clinical governance**
 - Robust clinical governance ensures appropriate standards of care can be maintained, continuous quality improvement is embedded and clinical risk is minimised.
- **Workforce**
 - A skilled workforce with the capacity and capability required will deliver high quality, safe and culturally competent treatment and care.

- PHNs as Learning Organisations
 - A culture of learning through experience and embracing new knowledge through training, education and research, including through partnerships with academic and professional bodies, will assist PHNs to focus on evidence based care.
- Digital delivery and enablement
 - Digital health services provide evidence based treatments that are accessible at the time and place that consumers want. They offer an opportunity to support a stepped care approach to service delivery, and are able to be scaled up, often at lower cost than traditional face to face services, but require a national approach.
- Standards and Government targets
 - The National Safety and Quality Health Service Standards and the National Standards for Mental Health Services guide PHNs and service providers to deliver care to an optimal standard. Government targets help services to prioritise resource allocation and achieve results.

These critical success factors and enablers are reflected in the actions set out in the *Five Year Horizon for PHNs* but also underpin the recommendations outlined below.

Summary

The PHN Advisory Panel on Mental Health was convened to provide advice to the Minister for Health in the wake of differing opinions about the progress of mental health reform being implemented through PHNs.

The Panel found that while PHNs are at differing levels of change readiness and change adoption, reflecting in large part their differing levels of governance and operational maturity, all PHNs have commenced on the journey towards transforming mental health services in their region.

Perhaps not surprising for such a fundamental shift in the way healthcare services are planned for and funded at the regional level, the Panel found that much of the differing opinions reflected tensions inherent in the devolved commissioning model. In particular, the tensions between regional autonomy versus national consistency and between evidence based services versus scope for innovation were clearly articulated through the consultations and debate. Each represents a dimension that is fundamental to the reform process but where the right answer will be found in balancing these competing pressures. A principles based approach must be applied to guide PHNs in their determination of the appropriate balance in their region.

The Panel also identified a number of key enablers for supporting reform and heard clear accounts of ways in which these enablers could be better addressed and enhanced to assist with the progress of reform. Suggestions to address these are encapsulated in the actions outlined in the Five Year Horizon document developed by the Panel and in the recommendations set out below for the consideration of the Minister for Health.

The diverse expertise of the panel provided rich and fertile grounds from which to consider and debate the opportunities and challenges associated with the current status of PHN mental health reform. The Panel was united on some matters and held differing views on others. This is perhaps not surprising considering the complexity of the mental health system, the diversity of its stakeholders and the magnitude of the transformation being enacted through PHNs.

Throughout, the Panel greatly valued the contribution of all stakeholders, their generous engagement with the process and the genuine intent observed towards collaborative system

change. There was a strong sense that the opportunity for stakeholders to come together and to share and better understand the different perspectives was particularly valuable.

Recommendations

The *Five Year Horizon for PHNs* document sets out actions for a range of stakeholders, reflecting the complex operating environment in which the mental health reform is occurring. In addition to these actions, the PHN Advisory Panel on Mental Health has developed recommendations to the Minister for Health to enhance the implementation of mental health reform through PHNs. They are set out in the table below, grouped by timeframe (not necessarily by priority) for implementation.

No.	Recommendation	Time frame
1	Government should continue its commitment to the integral role of PHNs in leading mental health reform and system transformation through regional needs assessment, planning and commissioning. This commitment is in line with the <i>Fifth National Mental Health and Suicide Prevention Plan</i> agreed by all governments. This commitment requires ongoing and expanded investment, consistent with progress.	Immediate (within 3 months)
2	Endorse and publically release the <i>Five Year Horizon for PHNs</i> as a key document supporting mental health reform and recommend that all actions contained within it are implemented in full.	Immediate (within 3 months)
3	As a matter of priority, provide PHNs with contract certainty (5 years) to allow more considered and timely planning, workforce development, and more appropriate commissioning cycles. Provisions should include a mandatory 12 month notice period if PHNs will be discontinued in order to avoid 'end of contract' uncertainty, which invariably affects service stability.	Immediate (within 3 months)
4	Enhance the funding available to PHNs to better support genuine co-design and partnership development, capacity building and workforce development.	Short term (within 12 months)
5	Review the Terms of Reference and the membership of the Mental Health Reform Stakeholder Advisory Group to enable it to provide ongoing advice on the implementation of the PHN reform program over the next 5 years. Functions including, but not limited to: <ul style="list-style-type: none"> - Review PHN activity and performance data - Advise the Department and the Minister on PHN mental health planning - Advise the Department and the Minister on best evidence regarding mental health services and programs with a view to supporting national standards 	Short-term (within 12 months)
6	Review and streamline the reporting requirements of PHNs to reduce their reporting compliance burden while maintaining appropriate levels of accountability, particularly in relation to service delivery, outcomes and innovation.	Short term (within 12 months)
7	Request the Australian Institute of Health and Welfare to include reporting on PHN mental health activity and performance as part of its MyHealthyCommunities site. This may allow benchmarking between 'like' PHNs across Australia.	Short term (within 12 months)

No.	Recommendation	Time frame
8	Support PHNs and other stakeholders to establish regular forums to ensure that information on best practice models derived from national and international evidence is widely disseminated and adopted. Note that deeper engagement across the mental health sector through national organisations could be utilised to provide PHNs with access to the most current research and technology across the spectrum of suicide prevention, stepped care and systems reform, as well as the implementation expertise to develop programs that fit within each region.	Short term (within 12 months)
9	Fund PHNs and other bodies as appropriate to ensure that learnings from the evaluation of innovative models of stepped care, including from the PHN trial sites, are promoted and disseminated to facilitate the broader uptake of successful models as appropriate.	Short term (within 12 months)
10	As a matter of priority, establish and appropriately fund consumer and carer representative bodies, including (but not limited to) a national consumer and carer peak representative body and ensure consumer and carer capability development in PHNs is appropriately funded and co-ordinated.	Short term (within 12 months)
11	Consider the potential incentives and levers that would support strong collaborative partnerships to facilitate co-commissioning of services across PHNs and LHNs and ACCHSs.	Short term (within 12 months)
12	Resource PHNs to develop and implement a regional workforce strategy based on a regional workforce needs assessment.	Short term (within 12 months)
13	Commission the development of a National Mental Health Workforce Development Strategy in collaboration with States and Territories and PHNs.	Medium term (1 -2 years)
14	Develop and fund opportunities for pooled funding and commissioning between mental health and alcohol and drugs and broader psychosocial support services.	Medium term (1 -2 years)
15	Harmonise data standards and data sets to enable comparable data to be collected by PHNs and include consumer and carer and family measures which can document improvements in care and treatment, and increases in the choice of services available, and include this data in annual reporting.	Medium term (1 – 2 years)
16	In consultation with PHNs, review the types of services and activities that would be more efficiently and effectively managed nationally, rather than by PHNs individually.	Medium term (1 – 2 years)
17	Commission the development and implementation of minimum standards for evidence-based practice which include guidelines for trialling new service models. This could foster and support the important role of PHNs to develop innovative service models and ensure that clinical risks are managed.	Medium term (1 -2 years)

Attachment 1

PHN Advisory Panel Membership

- Mr Frank Quinlan – Mental Health Australia (Co-Chair)
- Dr Peggy Brown – National Mental Health Commission (Co-Chair)
- Ms Abbe Anderson - Brisbane North Primary Health Network
- Ms Learne Durrington - WA Primary Health Alliance
- Mr Vahid Saberi - North Coast NSW Primary Health Network
- Ms Amanda Bresnan – Community Mental Health Australia
- Professor Lyn Littlefield – Australian Psychological Society
- Associate Professor Kim Ryan – College of Mental Health Nurses
- Dr Kym Jenkins – Royal Australian and New Zealand College of Psychiatrists
- Professor Pat McGorry - The National Centre of Excellence in Youth Mental Health
- Mrs Lucy Brogden – National Mental Health Commission
- Dr Morton Rawlin – Royal Australian College of General Practitioners
- Dr Mark Wenitong – Indigenous and remote health
- Mr Samuel Hockey – Youth lived experience
- Ms Lyn English - National Mental Health Consumer and Carer Forum

Attachment 2

PHN Advisory Panel Terms of Reference

Primary Health Networks (PHNs) have substantial responsibilities in mental health:

- plan and commission primary mental health care services at the regional level
- plan and coordinate the clinical service needs of people with severe and complex mental illness who are managed in primary care
- implement evidence-based stepped care
- integrate services in partnership with state and territory governments, general practitioners, non-government organisations, National Disability Insurance Scheme providers and other related services, organisations and providers.

The Primary Health Network Advisory Panel on Mental Health (the Panel) will serve five main functions:

1. To consider and provide advice regarding the guidelines for mental health commissioning issued to the 31 PHNs and oversee the development of a Framework for Primary Health Network mental health commissioning, noting that commissioning is a cyclical process of local consultation, local design and local solutions.
2. To oversee an analysis of the 2016/17 Department of Health-approved needs assessments and mental health plans developed by the 31 PHNs.
3. Following the analysis, provide advice to the Minister for Health on strategies to support the 31 PHNs to efficiently and effectively carry out their commissioning responsibilities in mental health.
4. Provide recommendations to the Minister for Health about the optimal system architecture and arrangements for supporting the role of PHNs in ongoing mental health reform.
5. Provide guidance for peak bodies and Colleges on how their members can engage with the PHN commissioning process

Process

The Panel will be time-limited. It will hold four meetings and conduct two PHN Forums. It will be assisted by independent consultants to:

- (i) develop a Framework for Primary Health Network mental health commissioning informed by the analysis of the guidelines for mental health commissioning
- (ii) undertake an analysis of needs assessments and mental health plans
- (iii) compile reports for individual PHNs based on the Framework
- (iv) compile an interim aggregate report in relation to PHN mental health commissioning and a final report for the Minister for Health.

Consultants will also assist with preparation of papers where necessary and provide independent facilitation for the two PHN forums.

Attachment 3

Organisations invited to the PHN Forums

ACT PHN
Adelaide PHN
AfterCare
Alcohol & Other Drug Policy Unit (ACT Health)
Apunipima Cape York Health Council
Australian Association of Psychologists incorporated (AAPi)
Australian Association of Social Workers
Australian Child & Adolescent Trauma, Loss & Grief Network
Australian Clinical Psychology Association (ACPA)
Australian College of Mental Health Nurses
Australian College of Rural and Remote Medicine
Australian Counselling Association
Australian Defence Force
Australian Healthcare and Hospitals Association
Australian Indigenous Psychologists Associations (AIPA)
Australian Institute for Suicide Research and Prevention
Australian Medical Association
Australian Private Hospitals Association
Australian Psychology Society
Australian Unity Limited
Baty
beyondblue
Black Dog Institute
Blue Knot Foundation
Brisbane North PHN
Brisbane South PHN
Butterfly Foundation
Carers Australia
Central and Eastern Sydney PHN
Central Queensland, Wide Bay, Sunshine Coast PHN
Centre of Best Practice in Aboriginal & Torres Strait Islander Suicide Prevention
CHESS Services
Community Mental Health Australia
Council on the Ageing, Australia
Country SA PHN
Country WA PHN
Darling Downs and West Moreton PHN
Department of Health NT
Department of Veterans Affairs
Early Childhood Australia
Eastern Melbourne PHN
Emerging Minds: National Workforce Centre for Child
Mental Health

Federation of Ethnic Communities Councils of Australia (FECCA)
Gippsland PHN
Gold Coast PHN
Headspace (National Youth Mental Health Foundation)
Hunter Institute of Mental Health- EVERYMIND
Hunter New England and Central Coast PHN
IAHA
Institute for Urban Indigenous Health
Lifeline Australia
MATES in Construction and Lives Lived Well
Mental Health Alcohol and Other Drugs Branch Queensland Health
Mental Health Australia
Mental Health Carers Australia
Mental Health Professionals Network
Mental Health, Alcohol and Drug Directorate,
Department of Health and Human Services
Mental Illness Fellowship Australia
Mindframe
Mindspot
Murray PHN
Murrumbidgee PHN
National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)
National Aboriginal Community Controlled Health Organisation
National Drug and Alcohol Research Centre
National Mental Health Commission
National Rural Health Alliance
Neami National
Nepean Blue Mountains PHN - Wentworth Healthcare Limited
New South Wales Institute of Psychiatry
North Coast PHN
North Western Melbourne PHN
Northern Queensland PHN
Northern Sydney PHN
Northern Territory PHN
NSW Council for Intellectual Disability
NSW Health
NSW Mental Health Commission
NSW Police, Mental Health Intervention Team
Occupational Therapy Australia
On The Line
Orygen
PANDA
Perth North PHN- WA Primary Health Alliance Limited
Perth South PHN
POCHE Indigenous Health Network
Private Mental Health Consumer & Carer Network

Psychotherapy & Counselling Federation of Australia
Queensland Ambulance Service
Queensland Centre for Mental Health Research
Queensland Mental Health Commission
R U OK?
ReachOut
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
SA Mental Health Commission
SANE Australia
South Eastern Melbourne PHN
South Eastern NSW PHN
South Western Sydney PHN
Suicide Prevention Australia
Tasmania PHN
Turning Point for AOD
United Synergies
WA Police - Licensing Enforcement Division
Wesley Mission/Wesley Lifeforce
Western NSW PHN
Western Queensland PHN
Western Sydney PHN
Western Victoria PHN

Attachment 4

Commissioning and Contracting for Better Mental Health Outcomes

Available at:

<https://mhaustralia.org/report/commissioning-and-contracting-better-mental-health-outcomes-report>

Attachment 5

Reform and System Transformation: A Five Year Horizon for PHNs

(Provided as a separate document)