Submission to the Productivity Commission Review of the National Mental Health and Suicide Prevention Agreement

Contact

Amanda Proposch
CEO, Gippsland PHN
Chair of the Mental Health and Alcohol and Other Drugs Coordination Committee | PHN Cooperative

Philip Amos
National Policy and Capacity Building Manager | Mental Health and Alcohol and Other Drugs

26th March 2025

Primary Health Network (PHN) Cooperative

Contents

Executive Summary

PHNs are key actors in the regional implementation of the National Mental Health and Suicide Prevention Agreement (NMHSPA or the Agreement). With deep regional system knowledge, and a mandate to coordinate, commission and capacity-build[1], PHNs' purpose is strongly aligned with the Agreement's objectives to 'build a better people-centred mental health and suicide prevention system for all Australians'[2].

The PHN Cooperative's submission reflects on the national Agreement through PHNs' experience of national and jurisdictional governance and the regional implementation of activities and programs. With expectations of a new Agreement in 2026, we offer recommendations for future Agreements, including clearer recognition of, and support for, the role that PHNs and the primary care sector can play in mental health and suicide prevention.

Over the term of the Agreement, PHNs have played a role of increasing importance in the national mental health and suicide prevention system, a system under pressure from barriers to equitable access to services, rising costs, cost of living impacts, and workforce challenges.

For PHNs, and our Local Hospital Network (LHN) counterparts, the Agreement's formalisation of joint regional planning and co-commissioning of co-funded programs is a significant change to our operating environment. PHNs have used our strong capabilities to deliver the programs and activities, however we have experienced challenges arising from the Agreement's governance and implementation.

Our submission highlights key challenges and opportunities under the Agreement, including the following.

- Deficiencies in the Agreement's governance negatively affected PHN's implementation of activities at the jurisdictional and regional level. In particular, the Agreement's governance and implementation did not authorise PHNs at a level commensurate with our responsibilities for programs and outcomes.
- Joint regional planning and commissioning are a necessary and positive first step towards better integrated systems, but the Agreement lacks effective incentives to translate planning into ongoing reform across Governments, PHNs and LHNs.
- PHNs are well positioned to contribute to national measurement and reporting under the Agreement by leveraging our regional mental health and suicide prevention data collection role, and our submission offers examples of scalable national architecture for this purpose.

[1] PHN Strategy 2023-24, DoHAC
[2] NMHSPA Part 2, para 20 (a)

Recommendations for Future Agreements

Governments can realise stronger outcomes from this and future Agreements by fully enabling and authorising PHNs to fulfil our role as meso-level organisations that drive integration and coordination within the Australian primary care system.

Our recommendations for future agreements are as follows.

Governance

1. Formally recognise PHNs in national and bilateral governance commensurate with our roles and responsibilities for deliverables under the Agreement.
2. Strengthen governance mechanisms for regional implementation of Agreement deliverables, including a clearer authorising environment for PHNs to plan, commission, and deliver ongoing regional system integration.
3. Adopt consistent governance and implementation frameworks across national Agreements, such as the National Health Reform Agreement, in which PHNs, LHNs, and Governments are engaged in comparable planning, integration, and system reform activities.

Planning and Commissioning

4. Increase national investment in the uptake of planning methodologies and tools to address challenges with training and retaining staff in the use of the National Mental Health Service Planning Framework at the regional level.
5. Implement regional processes for the adaptation of bilateral measures to local provider markets, such as in regional and remote regions where PHNs have strong commissioning expertise and market knowledge to contribute.

Data, Measurement and Reporting

6. Leverage PHN data assets and capabilities to develop national insights into program performance under the Agreement.
7. Strengthen national data collection, validation, quality, and conformance by leveraging PHNs' role as regional planners, commissioners and data custodians.
8. Enable increased data sharing at the regional and jurisdictional level, including data linkage of PHN and jurisdictional datasets, to support joint regional mental health and suicide prevention planning and commissioning.
9. Clearly define the target population who are intended to receive services from PHNs under the Agreement so that PHNs and LHNs will have a key reference point for planning and commissioning decision-making, and can develop frameworks for consistent and commensurable regional, state, and national reporting.

Workforce

10. Increase workforce development funding and program flexibility to meet regional needs, with a greater focus on innovation in service models, workforce and digital health.
11. Further develop workforce planning tools to the needs of primary mental health care.
12. Continue capacity building of the mental health and suicide prevention lived and living experience workforce.
13. Increase focus by the Australian Institute of Health and Welfare (AIHW) and other Commonwealth and State data collection bodies on breaking workforce data down by region and making this data available to PHNs and other key stakeholders involved in service planning.
14. A continued focus on multidisciplinary team care, recognising that in areas of thin or failing markets, the most effective delivery of mental health and suicide prevention services maybe by integrated Commonwealth and State and Territory workforce resources.
15. Provide greater flexibility to adapt program models to meet workforce availability in regional and remote areas, including innovative use of non-clinical and lived and living experience workforces.
16. Recognise PHNs' role in regional workforce needs assessments and planning, consistent with paragraph 144.

Suicide Prevention

17. Implement a streamlined and transparent communication process for funding allocations to ensure timely and clear updates for suicide prevention activities.
18. Align future Agreements with the National Suicide Prevention Strategy, including a strong focus on regional coordination of suicide prevention efforts to support systemic oversight, regional intelligence, sustainability and improvement.
19. Strengthen regional governance and implementation frameworks to enable the proposed expansion of joint suicide prevention planning articulated in the National Suicide Prevention Strategy.
20. Provide appropriate resourcing for PHNs to meet the added complexity and broader workplan required to implement actions under the Strategy.

Governance

The Agreement does not clearly define the role of PHNs in governance, noting only that the Parties to the agreement (Commonwealth, States and Territories) would engage with 'other relevant bodies' such as PHNs as required to implement reforms.

This lack of PHN role clarity has contributed to an unbalanced governance and implementation relationship at the regional level. PHNs have proven ability to drive coordinated regional action, but this is not routinely enabled by national governance and bilateral implementation mechanisms, incentives, or accountability frameworks that are commensurate with the Agreement's deliverables.

Recent national Reviews have recognised PHNs' capacity to act as local change agents to achieve integrated health outcomes at a regional level (Unleashing Potential of Health Workforce, Mid Term Review of NHRA, Primary Health Care 10 Year Review). However, the Agreement's governance and implementation have limited PHNs' ability to deploy our full capabilities.

PHNs' lack of formal participation in governance

PHNs had very limited participation or engagement with the Agreement's national governance forums and varying levels of participation in jurisdictional governance. This has hampered our ability to access timely and relevant information to inform our key role in regional planning, commissioning, and implementation. It has also meant that PHN local intelligence is not always drawn upon in co-design of actions at a jurisdictional or regional level.

Significant variation was experienced in the degree to which LHNs were required by jurisdictions to engage with PHNs. While PHNs had contractual deliverables to the Commonwealth for joint planning and commissioning, this was not consistently reciprocated in LHN arrangements. This created a dependency on PHN relationships with LHNs to drive collaboration, rather than formal implementation frameworks and shared responsibility.

One impact of the governance arrangements was the inconsistent flows of information to PHNs, including on key issues such as timing of co-funding, agreement of bilateral implementation plans, co-commissioning arrangements, and progress reporting.

Recommendations for future agreements

1. Formally recognise PHNs in national and bilateral governance commensurate with our roles and responsibilities for deliverables under the Agreement.
2. Strengthen governance mechanisms for regional implementation of Agreement deliverables, including a clearer authorising environment for PHNs to plan, commission, and deliver ongoing regional system integration.
3. Adopt consistent governance and implementation frameworks across national Agreements, such as the National Health Reform Agreement, in which PHNs, LHNs, and Governments are engaged in comparable planning, integration, and system reform activities.

Joint Regional Planning and Commissioning

PHNs support the Agreement's commitment to joint regional action

The Agreement's objectives to reduce fragmentation and improve systemic planning, commissioning and reform across Commonwealth and State and Territory mental health and suicide prevention systems are welcome. Duplication and ambiguity of responsibilities in mental health and suicide prevention systems continues to result in inefficiently targeted resources, services and associated system gaps.

For PHNs, the Agreement enacts a significant change to our operating environment, moving from a primarily vertical alignment under Department of Health and Aged Care (DoHAC or the Department) direction, to include a horizontal operating model in partnership with jurisdictions and LHNs for joint planning, co-investment, co-commissioning, and reporting.

Recognise the complexity of co-funding and commissioning

The objective of co-funding and co-commissioning regional mental health and suicide prevention programs is a positive. Co-funding and co-commissioning under the bilateral agreements has created a financial incentive that can drive deeper collaboration between PHNs and LHNs.

However, these new arrangements have added complexity to the PHN operating environment, requiring additional time and more resources to build and maintain effective working relationships. Generally, the complexity, cost and resource requirements are higher in PHN regions where there are multiple LHN partners for joint activities. In some PHN regions these additional costs are high and are not adequately resourced.

For example, the mechanics of implementing programs that are co-funded by Commonwealth and State or Territory Government adds risk and complexity to program design, management, reporting, and KPI processes. This means that a higher administrative burden falls on PHNs and commissioned service providers. In some cases, misaligned funding timelines between Commonwealth and State or Territory Government have delayed planning and commissioning processes. Increased PHN participation in governance and implementation planning would reducing this impact.

Joint regional planning requires recognition, authority and resourcing

The Agreement's focus on Joint Regional Mental Health and Suicide Prevention Plans was appropriate. However, the Agreement lacked the necessary regional enablers and authorising environment for PHNs to work with LHNs to translate the Plans into ongoing system integration and reform outcomes. Future Agreements will require greater recognition and investment in the resourcing, guidelines, quality frameworks, and mechanisms to enable effective planning and ongoing system integration and reform.

While PHNs and LHNs have a track record of partnering on emerging mental health issues, such as when responding to COVID, or management of complex conditions, and the concept of joint regional planning is not new, some LHNs are not routinely required or supported by jurisdictions to co-commission or to implement joint regional plans through contractual obligations.

The role envisaged for PHNs in the Agreement's regional planning and commissioning deliverables was inconsistently recognised by jurisdictions or LHNs. In general, there was engagement in the preparation of joint plans but a lack of ongoing commitment to implementation which may limit joint plans' impact.

Formal and informal implementation progress reporting was slow and not available to all PHNs in a timely manner. This led to some examples of duplicated reporting burdens at the regional and provider level. Clearer reporting arrangements down to the regional level would reduce this impact.

Failure to deliver national Guidelines for Joint Regional Planning

The Agreement required the Parties to work together to develop new national guidelines on regional planning and commissioning (paragraph 133). The Parties' failure to deliver these Guidelines contributed to uncertainty at the regional level. The one-page National Principles for Regional Planning and Commissioning of Mental Health and Suicide Prevention Services did not provide useful clarity, practical guidance or promotion of best practice for regional planning implementation.

In 2018 under the Fifth National Mental Health Plan implementation, the Commonwealth, States and Territories together with a range of key stakeholders including PHNs and people with lived and living experience, prepared *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: A Guide for Local Health Networks (LHNs) and Primary Health Networks (PHNs)*.

This Guide, which is still on the Department of Health and Aged Care's website, was supported by a Compendium of Resources to support joint regional planning, which provided advice on the data and other resources available to inform regional planning, and on the use of the National Mental Health Service Planning Framework for joint planning. Whilst this Guide and the compendium is now out of date, it points to the sort of substantial and practical guidance which is needed to assist PHNs and LHNs work together, and which is possible to develop.

The Agreement sought alignment with actions in the National Health Reform Agreement regarding joint planning, particularly proposed bilateral state-wide planning between PHNs and state and territory organisations (paragraph 140). This did not occur routinely across jurisdictions. As suggested earlier, alignment of governance frameworks would support more effective and timely engagement by PHNs in planning and co-design.

As outlined in the following section, there will also need to be alignment or extension of scope of joint regional mental health and suicide prevention planning to accommodate stakeholder engagement and other expectations of joint suicide prevention plans articulated in the National Suicide Prevention Strategy.

Recommendations for future agreements

4. Increase national investment in the uptake of planning methodologies and tools to address challenges with training and retaining staff in the use of the National Mental Health Service Planning Framework at the regional level.

5. Implement regional processes for the adaptation of bilateral measures to local provider markets, such as in regional and remote regions where PHNs have strong commissioning expertise and market knowledge to contribute.

Data, Measurement and Reporting

The Agreement aims to improve the mental health of all Australians and explicitly recognises that 'comprehensive, accurate and accessible information is critical to mental health and suicide prevention system reform' (paragraph 80). Progress towards achieving these aims is undertaken using the National Mental Health and Suicide Prevention Information Priorities and detailed in the Technical Implementation Plan.

Central to these Information Priorities are a set of empirical questions developed by Leginski and colleagues to address the information needs of mental health system managers: "Who receives, what services from whom, at what cost, and with what effect?" [3].

The Leginski questions establish a broad framework that can be used to develop balanced responses at several levels (local, regional, state/territory, and national) including identifying gaps and weaknesses in relation to achieving the National Mental Health and Suicide Prevention Agreement objectives. PHNs provide one of the core data sources for this undertaking via the Primary Mental Health Care – Minimum Data Set (PMHC-MDS).

Current data collection, measurement and reporting frameworks do not reflect the targeted contribution PHNs currently make through coordination and commissioning to improve integration and address gaps in the mental health and suicide prevention system as identified in the Agreement. Nor do they focus on the regional data needed to facilitate joint efforts by LHNs and PHNs in reducing system fragmentation or the fundamental changes to the way information needs to be represented, understood and acted on by PHNs as a key driver of progress towards nationally agreed objectives.

PHNs support further investment to address limitations in measuring and reporting national progress against the Agreement's aims and objectives as follows.

- National measurement and reporting are limited by the lack of a clearly defined target population who are intended to receive services from PHNs under the Agreement.

[3] Leginski, Croze C, & Driggers J. (1989). *Data standards for mental health decision support systems. A report of the task force to revise the data content and system guidelines of the mental health statistics improvement program*. Washington,. University of Michigan Library.

- There is insufficient investment in strengthening national data collection, validation, quality, and conformance.
- National and State and Territory data collections are not consistently made available to inform joint regional planning and monitoring.
- There is insufficient investment in systematic availability of improved regional mental health workforce data and data linkages.

PHNs are custodians of mental health and suicide prevention data assets, which, together with our knowledge of regional mental health and suicide prevention systems, can be used to create scalable frameworks for national monitoring and reporting.

As trusted regional planning and commissioning bodies, PHNs are well placed to contribute to the development of national measures and progress indicators for activity under the Agreement.

Over the term of the Agreement, PHNs have developed a national project for cross-PHN PMHC-MDS data pooling and analysis using the Primary Health Insights platform to create national insights into mental health and suicide prevention program performance (refer to Appendix 1 for a case study of this Project).

Recommendations for future agreements

PHNs are seeking a stronger partnership with the Parties to contribute to improved data, measurement, and reporting systems in future Agreements, as follows.

6. Leverage PHN data assets and capabilities to develop national insights into program performance under the Agreement.
7. Strengthen national data collection, validation, quality, and conformance by leveraging PHNs' role as regional planners, commissioners and data custodians.
8. Enable increased data sharing at the regional and jurisdictional level, including data linkage of PHN and jurisdictional datasets, to support joint regional mental health and suicide prevention planning and commissioning.
9. Clearly define the target population who are intended to receive services from PHNs under the Agreement so that PHNs and LHNs will have a key reference point for planning and commissioning decision-making, and can develop frameworks for consistent and commensurable regional, state, and national reporting.

This work can be progressed through collaboration between DoHAC, State and Territories, the AIHW, and PHNs under the Agreement's Technical Implementation Plan.

PHNs' Role in Regional System Reform

The Agreement reflected the growing recognition over recent years that to achieve integrated mental health and suicide prevention service systems in Australia, reform needs to take place at a regional as well as a jurisdictional level. However, neither the Agreement itself, nor its implementation through bilateral agreements has fully enabled or authorised the potential role of PHNs at the regional level in the co-design, planning and commissioning of community based mental health and suicide prevention services.

Over the last 10 years, PHNs have become a core element of the primary care system as meso-level organisations promoting coordination and integration. PHNs are the key regional commissioning organisations within the Australian primary health care system. At a system level, PHNs have proven they can operate at the regional level to coordinate, integrate and facilitate data collection and monitoring and to support swift, agile responses to public health or emergency challenges. They need authority and recognition by Parties in agreements to deliver the best outcomes.

PHNs have played an important role in planning, coordinating and commissioning in the mental health and suicide prevention system. PHNs are uniquely positioned to add value to mental health and suicide prevention reform as follows.

- System coordination and integration: identifying gaps and working to address them
- Collaboration and building relationships: PHNs have well developed networks and trusted relationships with LHNs, service providers and the community
- Data: collation of data and local intelligence to inform planning and commissioning
- Communication: offering a conduit to the regional primary care system
- Commissioning: regional commissioning of place-based services to target community needs.

The ability of PHNs to act as local change agents to achieve integrated health outcomes at a regional level and support and build the capacity of the primary care workforce has been recognised in recent reviews and plans including Unleashing the Potential of Our Health Workforce, 2024[4], the Mid Term Review of the National Health Reform Agreement (NHRA),[5] and Australia's Primary Health Care 10 year Plan, 2022-2032. [6] These reports and plans have also highlighted the role of PHNs in supporting and building the capacity of the primary care workforce and in promoting multidisciplinary team care within and beyond primary care.

[4] https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report.
[5] https://www.health.gov.au/sites/default/files/2023-12/nhra-mid-term-review-final-report-october-2023.pdf
[6] https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en

PHNs have a strong track record in planning and commissioning services for the priority groups and needs identified in the Agreement including but not limited to initiatives subject to bilateral agreements. The agility of PHN commissioning to coordinate regional community responses to emerging regional mental health and suicide prevention needs was demonstrated in responses to bushfires and other natural disasters, and in the public health response to COVID-19.

PHNs also support a 'one system' approach to regional primary mental health care, supporting integration of mental health, physical health, AOD issues and a bridge to jurisdictional services. This is consistent with the Agreement's vision for an integrated and agile mental health system. However, it was not enabled by the critical governance, by the roles and responsibilities articulated, nor by the bilateral agreements.

To optimise the role of PHNs in supporting integrated mental health and suicide prevention service systems at a regional level, the following enablers are required.

- PHNs need to be formally recognised and authorised through key national and bilateral agreements as key partners in jurisdictional and regional mental health and suicide prevention planning, and commissioning, including in co-design.
- PHN expertise must be included in governance arrangements – this will also assist swifter implementation of joint funding arrangements.
- PHNs' role in coordinating primary mental health care and suicide prevention services should be recognised, empowered and harnessed through a consistent authorising environment
- The above roles should be resourced to align with the lifespan of key agreements to give certainty to the roles and responsibilities anticipated.

Workforce is Essential to Delivering Outcomes

The Agreement is underpinned by an expectation that Australian governments will collaborate at a regional level to "jointly determine community needs and plan the response to these needs, including assessment of the required mental health and suicide prevention workforce" (paragraph 144). The Agreement also promoted multidisciplinary care and optimal use, and distribution of the mental health and suicide prevention workforce in accordance with agreed scopes of practice (paragraph 158).

From a primary care perspective, PHNs note the Commonwealth has made good progress in this area in terms of several initiatives and focused reviews seeking to promote and support multidisciplinary team care in primary care and to make optimal use of available skills. This includes:

- Unleashing the Potential of the Health Workforce - The Scope of practice review
- Strengthening Medicare initiatives, which emphasise multidisciplinary team care
- National Allied Health Workforce Strategy

Similarly, the Commonwealth has focused on opportunities to address areas of thin and failing markets in primary care, including in rural, regional and remote settings through exploring options to better recruit, retain and support workforce, and where this is not possible, to offer other solutions, including digital measures.

These initiatives have all recognised the role PHNs can play at a regional level to support workforce planning, recruitment, retention and capacity building. This includes gathering local intelligence on current and anticipated supply of workforce needed to build appropriate multidisciplinary teams that work within and beyond primary care, and in leading joint regional workforce planning, including in regions of thin or failing markets. A growing recognition of the role digital workforce solutions and the lived and living experience workforce can play has been part of this.

In terms of governments working together, the focus of joint activity appears to have been supporting the completion of the National Mental Health Workforce Strategy, which was published in 2023 by the National Mental Health Commission. PHNs are disappointed that, unlike other major reviews and reports mentioned above, the National Mental Health Workforce Strategy omitted to identify the important partnership needed with regional organisations such as PHNs in achieving the strategic pillars of action.

In general, PHNs have been disappointed that the Agreement has not enabled the development of fit for purpose regional data and tools to inform mental health service planning:

- The National Mental Health Service Planning Framework is an evidence based and comprehensive planning tool but remains more geared towards the state public mental health sector than the primary mental health sector where PHNs are commissioning community managed organisations for service delivery.
- PHNs play a valuable role in collecting regional workforce data, as identified elsewhere in this submission, however there is a lack of easy access to regional mental health workforce data on a regional basis. For example, it's difficult for PHNs or LHNs to reliably know how many allied health professionals there may be available to work in mental health in a region.

Recommendations for future agreements

PHNs would like to see a clearer recognition of the role of PHNs in supporting collaboration at a regional level to determine needs and undertake workforce planning, consistent with paragraph 144.

In general, future Agreements or any revision of the National Mental Health Workforce Strategy, should address:

10. Increase workforce development funding and program flexibility to meet regional needs, with a greater focus on innovation in service models, workforce and digital health.
11. Further develop workforce planning tools to the needs of primary mental health care.

12. Continue capacity building of the mental health and suicide prevention lived and living experience workforce.
13. Increase focus by the Australian Institute of Health and Welfare (AIHW) and other Commonwealth and State data collection bodies on breaking workforce data down by region and making this data available to PHNs and other key stakeholders involved in service planning.
14. A continued focus on multidisciplinary team care, recognising that in areas of thin or failing markets, the most effective delivery of mental health and suicide prevention services maybe by integrated Commonwealth and State and Territory workforce resources.
15. Provide greater flexibility to adapt program models to meet workforce availability in regional and remote areas, including innovative use of non-clinical and lived and living experience workforces.
16. Recognise PHNs' role in regional workforce needs assessments and planning, consistent with paragraph 144.

Suicide Prevention

Alignment with the National Suicide Prevention Strategy

The National Mental Health and Suicide Prevention Agreement is a shared commitment to transform and improve Australia's mental health and suicide prevention system by implementing an effective approach to the needs of people at risk of suicide. The priority given to suicide prevention both through the Agreement and the bilaterals was appropriate.

Future agreements should reflect the emerging suicide prevention system, particularly in prevention which is distinct from the mental health system, as well as the areas in which mental health and suicide prevention are united.

The National Suicide Prevention Strategy, published in early 2025, provides a broad range of actions which can be progressed through or aligned with future Agreements. The 'Strengthening Regional Suicide Prevention' section of the Strategy is particularly relevant to the momentum the Agreement sought to initiate at a regional level.

There are significant opportunities for action including the following.

- Providing clarity on the role and responsibility for suicide prevention regional coordination which has been developed under the National Suicide Prevention Trials (NSPT) and Targeted Regional Initiatives for Suicide Prevention (TRISP). The importance of dedicated regional suicide prevention coordinators has been highlighted through these initiatives. Following the conclusion of these programs, there remains a need for regional roles that are dedicated to systemic oversight, regional intelligence, sustainability and continuous improvement.

- Expansion of Aftercare services to be available to anyone who has self-harmed, attempted suicide or experienced a suicidal risk. A future Agreement may need to consider how this model could be further developed to meet a spectrum of needs.
- Strengthening data availability for suicide prevention planning and commissioning, noting challenges from under-reporting and stigma particularly in regional and remote areas. Improved data will strengthen PHN capability to drive local solutions and system reforms.

The National Suicide Prevention Strategy expectations for joint regional suicide prevention plans and responses

The National Suicide Prevention Strategy foreshadows an expansion of joint regional suicide prevention planning to include local government and Aboriginal Community Controlled Health Organisations.

The NSPS action c31.3 introduces a requirement for 'primary health networks, local hospital networks, and local governments to partner with each other as well as local Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Organisations in the planning and delivery of regional suicide prevention plans and responses.'

PHNs support the important role that local councils and Aboriginal Community Controlled Organisations play in suicide prevention. PHNs currently work effectively with Aboriginal Community Controlled Health Organisations in regional mental health and suicide prevention planning and commissioning, including under the current Agreement.

Partnerships between PHNs and local councils in the context of disaster response have shown the value and potential of these partnerships. At a practical level, we note that in some PHN regions there are multiple councils. For example, PHNs in Western Australia have the challenge of collaborating with 43 local councils.

Noting the challenges with regional governance and engagement under the current Agreement, an expansion of planning requirements will present logistical challenges if joint endorsement of suicide prevention plans is anticipated, particularly as many local councils are resource challenged.

A future Agreement should align where possible with The National Suicide Prevention Strategy. In this respect it should ensure that joint regional mental health and suicide prevention planning considers the broader engagement required for suicide prevention planning or aligns or incorporates more detailed suicide prevention plan preparation. It should also acknowledge the additional resources and complexity involved in the extension of regional suicide prevention planning.

Recommendations for future agreements

17. Implement a streamlined and transparent communication process for funding allocations to ensure timely and clear updates for suicide prevention activities.
18. Align future Agreements with the National Suicide Prevention Strategy, including a strong focus on regional coordination of suicide prevention efforts to support systemic oversight, regional intelligence, sustainability and improvement.
19. Strengthen regional governance and implementation frameworks to enable the proposed expansion of joint suicide prevention planning articulated in the National Suicide Prevention Strategy.
20. Provide appropriate resourcing for PHNs to meet the added complexity and broader workplan required to implement actions under the Strategy.

Appendix

Case Study: How PHNs are scaling PMHC-MDS data for national insight

The following case study illustrates how a group of PHNs have collaborated to overcome a key mental health program constraint — there is no national level detailed analysis of PMHC-MDS data that is available to PHNs for program management.

In 2021, to address this need, 11 PHNs agreed to use the Primary Health Insights[7] platform to pool their PMHC-MDS data for joint analysis and benchmarking on service delivery, cost and outcomes. The Project is known as the PMHC-MDS Collaboration.

The PMHC-MDS was chosen for this purpose, reflecting both the materiality of mental health service commissioning by PHNs and the quality of the data comprising the MDS data collection. This quality reflects the PMHC-MDS's replicable data standards and definitions, which are well-understood and incorporated into PHN and commissioned service provider reporting.

The PMHC-MDS Collaboration uses the Primary Health Insights platform to securely pool PMHC-MDS data from PHNs and then applies the Leginski questions to the unified dataset to yield comparable insights into:

> "who receives, what services from whom, at what cost, and with what effect?"

With insights from four years of data, the PMHC-MDS Collaboration is a unique tool as it offers insights into program performance that would otherwise not be available to a single PHN, including:

- value in volume, i.e. patterns that an individual PHN could not detect
- key differences, i.e. aspects that are unique to a PHN and help explain different outcome measures.

How the PMHC-MDS Collaboration is improving PHN capability

PHNs have previously struggled to interpret changes in K10 scores using the official PMHC-MDS classifications of:

- "significant improvement" (score decreases by five or more),
- "significant deterioration" (score increases by five or more), and
- "no significant change" (score changes by less than five).

This is because clients with lower levels of initial psychological distress are far less likely to experience "significant improvement". A service for clients presenting with moderate psychological distress should not be judged adversely if it reports a lower "improvement" rate than a service for clients presenting with severe distress.

[7] www.primaryhealthinsights.org.au

The PMHC-MDS Collaboration project elegantly addresses this issue by creating a dashboard that presents stratified K10 score changes into categories of initial psychological distress. It is reassuring to see similar patterns in this stratified plot when large four-year datasets are compared between PHNs. The plots provide a good way to track trends, and there is opportunity for a national, aggregated version of the plot to provide a very useful benchmark for all PHNs.

The pooling of MDS data from multiple PHNs enables collective insights to be identified. For example, among the participating PHNs the data shows that:

- the more acute the initial psychological distress, the more likely a client is to have a positive outcome with significant improvement
- telehealth consults increased over the last three years, face-to-face consults remained stable, and time from referral to first contact decreased
- principal focus of treatment (Low Intensity, Psychological Therapy, Clinical Care Coordination) service mix has a high variation between PHNs.

Next steps

The PHN Cooperative is seeking to work with the Department of Health and Aged Care on the future development of the Collaboration. We believe that with further development the Collaboration has potential to meet PHN and Government needs for actionable insights into mental health and suicide prevention activity and performance.

Currently, the Collaboration is a proof-of-concept project to test to capacity of the Primary Health Insights platform to create shared PHN data from which service and performance insights could be generated. The Collaboration is hosted by WAPHA with a five-PHN Steering Committee for governance.

The number of PHNs that have joined the collaboration has risen gradually over the last two years. Currently 21 (of 31) PHNs have signed on to the Collaborative, and 19 (of 21) have uploaded data to the Collaborative zone.